Health Care Financing

Grants and Contracts Report

Health Maintenance Organization Risk Contracting Under Medicare

Health Care Financing Administration

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The Office of Research and Demonstrations, Health Care Financing Administration, directs more than 300 intramural and extramural research, demonstration, and evaluation projects. These projects seek alternate ways to finance, organize, and deliver health services, as well as assess the impact of Federal programs on health care costs, providers, and beneficiaries. The Health Care Financing *Grants and Contracts Report* series represents reports from selected extramural projects funded by the Office of Research and Demonstrations. The statements and data contained in each report are solely those of the contractor or grantee and do not express any official opinion of or endorsment by the Health Care Financing Administration.

Health Maintenance Organization Risk Contracting Under Medicare describes the operational aspects of health maintenance organizations (HMO's) and competitive medical plan risk-based contracting with the Medicare program. This report discusses the financial, marketing, health care delivery, and contract administration considerations surrounding Medicare risk-based contracting based on the experience of eight Medicare capitation demonstrations which began in 1980. They were the first instance of HMO's which provided Medicare benefits under full- risk, prospectively determined capitation rates without the Health Care Financing Administration's retroactive adjustment of an HMO's actual costs.

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Health Maintenance Organization
Risk Contracting Under Medicare

U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
Baltimore, Maryland
September 1984

This report was prepared under Health Care Financing Administration (HCFA) Contract No. 500-81-0017 between HCFA and Jurgovan and Blair, Inc. The project directors were David E. Edman and David L. Weiss. The Federal project officer was Alan Friedlob of HCFA. The authors wish to acknowledge the contributions of Bruce Carpenter, Frances Christmon, and Emanuel Sandberg.

For sale by the Superintendent of Documents, U.S. Government Printing Office Washington, D.C. 20402

HMO RISK CONTRACTING UNDER MEDICARE

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I. INTRODUCTION

Since the early 1970s, public policy decision makers have debated the proper role for HMOs in providing and financing medical care services to the elderly. Contracting options for HMOs with Medicare programs have historically been cost-based systems of reimbursement, with only limited opportunities for HMOs to assume risk and benefit from savings. HMO advocates historically have argued that the federal government neglected to take advantage of the cost-savings potential of the HMO industry by failing to pass legislation to allow prospective payment of HMOs under the Medicare program.

This changed with the passage of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). TEFRA amended the Social Security Act to permit prospective payment of eligible HMOs and so called "competitive medical plans" which render health care services to Medicare beneficiaries. Though the debate about the proper role of HMOs in the Medicare program is likely to continue, attention is now shifting to the operational issues confronted by health care organizations that seek to establish Medicare risk contracts under the new law. The purpose of this document is to present the issues related to developing a risk contract with the Health Care Financing Administration (HCFA), and assist those plans that wish to serve Medicare beneficiaries by implementing a risk contract.

In 1978, HCFA authorized HMO Capitation Demonstration Projects in order to shed light on the many technical issues related to prepaid contracting under Medicare. The principles of Medicare risk contracting employed under the Demonstration Project are similar to those incorporated into the new law. Therefore, the experience of the HMOs under the Demonstration is potentially valuable to HMOs and competitive medical plans (CMPs) considering risk contracting under Medicare. The experiences of the Demonstration HMOs have been used in preparing this paper. This document is part of an overall evaluation of the HMO Capitation Demonstration Project conducted by Jurgovan and Blair, Inc. for HCFA's Office of Research and Demonstrations.

The Demonstration HMOs and their operational start-up dates are as follows:

1. Fallon Community Health Plan, Worcester, Massachusetts (April 1980)

2. Greater Marshfield Community Health Plan, Marshfield, Wisconsin (June 1980)

3. Kaiser Foundation Health Plan, Portland, Oregon (August 1980).

4. Interstudy, Minneapolis/St. Paul, Minnesota
   Share (December 1980)
   MedCenter (July 1981)
   Nicollet-Eitel (July 1981)
   HMO Minnesota (July 1981)

5. Health Central, Lansing, Michigan (September 1981)

A brief summary of each of the Demonstrations is contained in Section V.

The original design of the capitation demonstration program, designed to test principles of Medicare contracting with HMOs on a prepaid, per-capita basis, had the following basic elements:

- The HMO would establish an adjusted community rate (ACR) for the Medicare population -- the estimated per capita cost (plus the HMO's usual retention factor) for the HMO to provide Medicare benefits to its Medicare membership.

- HCFA would calculate an adjusted average per capita cost (AAPCC) for each county from which Medicare beneficiaries are enrolled in a Demonstration HMO. The AAPCC is an estimate of what it would have cost HCFA if the individuals enrolled in the HMO had received benefits in the fee-for-service sector (see section IV.A. for a detailed description of how AAPCC is defined and calculated).

- The HMO would receive a prospective payment from HCFA, with no retrospective adjustment, generally equal to 95% of the AAPCC.

- For most HMOs, 95% of AAPCC would exceed ACR. The HMO would be obligated to use the difference between 95% of AAPCC and ACR to give the Medicare beneficiaries additional benefits not normally covered by Medicare or to reduce cost-sharing.

Certain variations on the above approach to Medicare risk contracting did appear under the Demonstration. These variations will be highlighted in this document. The approach described above, however, is essentially the same as that which will be employed under TEFRA, making the Demonstration experience valuable to HMOs and other organizations considering the merits of prepaid contracting for Medicare.

The remainder of this document discusses the issues that should be addressed by an HMO when considering whether or not to establish a risk contract under Medicare. Section II describes the contracting options currently available to HMOs under the Social Security Act, and presents a brief historical overview of how Section 1876 evolved to its present format. This section also includes a description of the current level of Medicare benefits and costs to the beneficiary.

Section III of this document describes basic guidelines relative to Medicare risk contracting, under TEFRA including who is eligible to contract with HCFA on a risk basis and, the process of establishing a risk contract. These guidelines are based on the Statutory provisions of TEFRA pertaining to HMO Medicare Risk Contracting and not on regulations implementing this law which have not yet been finalized. This section will emphasize technical questions relating to submission of a benefit package, determination of an adjusted community rate (ACR), and development of a marketing plan, as well as HCFA approval and reporting requirements.

Section IV will detail various operational aspects of a Medicare risk contract, divided into the following functional areas:

- Financial Management
- Marketing Management
- Health Care Delivery
- Contract Administration

Each section identifies important operational issues and suggests strategies for how HMOs and competitive medical plans (CMPs) considering Medicare risk contracting can address these concerns. Discussion is based in large part on information gathered from structured interviews with key Demonstration site personnel, and observations by HCFA's evaluators over a two and one-half year period.

Finally, the last section of this document is a summary of the Demonstration case studies. A review of the problems, approaches, and results at each of the original Medicare Demonstration Programs will be presented. The actual experience of the Demonstration Plans will be related in a structured way to the issues discussed previously. The experience of the HMO Demonstrations can be valuable to HMOs and CMPs considering Medicare risk contracting for the first time.

II. MEDICARE LAW AND REGULATIONS

A. Brief Historic Overview

In 1965, the United States Congress determined that as a matter of public policy, health care services provided to this country's aged population would be financed in large part by the Federal Government. By passing Title XVIII of the Social Security Act, entitled Health Insurance for the Aged and Disabled,[1] Congress created the program commonly known as Medicare to provide insurance coverage for a wide array of institutional and professional services to eligible beneficiaries.

From the inception of Medicare there has been recognition in the law and in public policy of the desirablility of allowing for the participation of prepaid health delivery entitities commonly known as HMOs in the program. More importantly, there was a desire for HMOs to participate in a manner which would take advantage of an assumed cost-effectiveness of such plans, and to make alternative health delivery systems more generally available to the Medicare beneficiaries.

Since Medicare began in 1966, the vast majority of HMO participation has been on a cost-reimbursement basis, in accordance with either Section 1833 or Section 1876 of the Social Security Act. The original Title XVIII of the Social Security Act, which introduced Medicare, provided, in Section 1833(a)(1), that "an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under (the provisions of Part B of Medicare)..."

From this provision of the law stemmed the authority of so-called Group Practice Prepayment Plans (GPPPs) to contract for cost reimbursement with the Medicare Program for Part B payments (covering

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1 The Social Security Amendments of 1972 amended the Act by adding "And Disabled" to the title of Title XVIII and adding a new class of eligible beneficiaries.

medical and other professional services). Appendix A to this document contains a summary of Medicare benefits.

The Social Security Amendments of 1972, which added Section 1876 to the Act, allowed for either "cost" or "risk" basis contracting by HMOs and for coverage of both Part A and Part B services for eligible beneficiaries.

Under a cost contract with the Medicare program, payment to the HMO is based upon an initial budget submitted by the HMO to HCFA. This results in an interim monthly capitation payment from HCFA to the HMO. This payment can be adjusted based upon budget and accounting rules for cost contracting. The Plan must submit regular cost reports which reflect HCFA regulations for determining which costs are allowable, measuring the actuarial equivalent of deductibles and copayments, allocating general and administrative expenses, and "weighting" of Medicare services[2].

Unlike GPPP programs, cost-basis HMOs may accept Part A and B payments if they desire. However, most have chosen to receive Part B payments only and allow for hospitals to receive payments directly from HCFA or an intermediary for inpatient services that are arranged for members. It should be noted that this type of arrangement, which has been established by 63 HMOs with about 110,000 Medicare members, still does not provide the HMOs with the financial incentives that are the result of true prospective payment, and still imposes upon the HMOs

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2 For a detailed description of these procedures, see the Medicare Group Practice Prepayment Plan Manual, HIM-8 (12-77). U.S. Department of Health and Human Services.

the burden and uncertainty of cost reporting and retrospective adjustment.

"Risk" basis reimbursement, according to Section 1876 prior to TEFRA also involves a budget-based interim capitation, and a retrospective cost-based adjustment. This type of risk contracting was available only to "mature" HMOs, defined in part as those with 25,000 or more enrollees and will no longer be available to HMOs after TEFRA goes into effect. Under this arrangement, the HMO's allowable cost is compared with a retrospectively determined adjusted average per capita cost (AAPCC). AAPCC is meant to measure what it would have cost HCFA if the HMO members had received services in the fee-for-service sector. If the HMO's actual cost is greater than the AAPCC, the HMO must absorb the differences. Losses may be carried over and deducted from savings in future years, however. If the HMO's cost is less than the retrospective AAPCC, such "savings" are divided equally between the government and the HMO, up to 20% of the AAPCC. Thus, an HMO can incur and keep "savings" up to 10% of the AAPCC. Any total "savings" beyond 20% of the AAPCC are retained by the government.

Therefore, while the HMO's downside "risk" is unlimited, its positive incentive is limited. Also, "savings-sharing" and retrospective cost adjustment remain integral parts of the procedure and are incompatible with HMO recordkeeping. Only one HMO, Group Health Cooperative (GHC) of Puget Sound, has operated under such a contract for any length of time.[3]

Section 114 of TEFRA, which amends Section 1876 of the Social Security Act, permits true prospective risk contracting without retrospective adjustments based upon actual costs. HMOs and competitive medical plans (CMPs) that assume risk under the new Section 1876 will receive a prospective payment equal to 95% of AAPCC. At a minimum,

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3 Two other HMOs, International Medical Centers HMO and Health Care of Broward established risk contracts as an interim step between a Medicare cost contract and Medicare Capitation Demonstration Programs.

the HMO or CMP must provide the current level of Medicare benefits. The HMO or CMP may provide benefits above the statutory minimum, and may charge a premium to the beneficiary. The important concept is that the HMO or CMP assumes total risk -- receiving no additional money if costs are higher than expected and returns none of its revenues to HCFA if costs are lower than expected. However, Section 1876 does restrict "savings", defined as the difference between expected capitated revenue (95% of AAPCC) and the expected cost for providing benefits to the Medicare population (adjusted community rate). Anticipated "savings" must be returned to the Medicare beneficiary through additional benefits (beyond what is normally covered by Medicare) or through reduced cost sharing (premiums, deductibles, and copayments).

Under the new Section 1876, cost contracting remains an option for HMOs. There are many reasons why an HMO that does not have any Medicare enrollment might elect to establish a cost contract rather than a risk contract under Section 1876. These reasons include a lack of experience serving Medicare beneficiaries and insufficient data from which to project costs; the inherent nature of this population, which requires assuming a greater risk than the plan would be subjected to from younger, ostensibly healthier population groups; or limits on plan capacity to assume the higher than normal service demands of the Medicare population.

In summary, once provisions of TEFRA are implemented, HMOs and similar health care entities will have three basic contracting options under the Social Security Act: Section 1876 risk contract, a Section 1876 cost contract, and a Health Care Prepayment Plan Contract under Section 1833. The remainder of this document will focus on the first option, Medicare risk contracting. One requirement for organizations with such contracts is that they provide a broader benefit package than existing Medicare Part A and Part B benefits, which are briefly described below. A detailed description of Medicare Part A and Part B benefits is presented as Appendix A.

B. Current Statutory Benefits

Under the Social Security Act, benefits offered to eligible beneficiaries are divided into Part A and Part B. Part A benefits cover inpatient hospital services, skilled nursing services, home health care, and hospice care. Inpatient hospital services are covered up to 90 days in the same "spell of illness", subject in 1984 to payment of a deductible amount of $356 and a daily copayment after 60 days of $89 per day. After 90 days, a beneficiary is entitled to 60 "lifetime reserve" days, also subject to a copayment of $178 per day. Care in a skilled nursing facility is covered up to 100 days per benefit period, subject to a copayment after the 20th day of $44.50 per day. These deductibles and copayments change annually and in proportion geared to varying percentages of the inpatient deductible.

Part B benefits include professional and outpatient services. Medicare beneficiaries are required to pay a monthly premium for services provided under Part B. The premium, currently $14.60, is deducted from the beneficiary's Social Security check. Medicare Part B (except for home health care) also carries a $75.00 annual deductible, plus a beneficiary copayment of 20% of all "reasonable charges", as stipulated by the Social Security Act. Beneficiaries may be billed for charges above Medicare's definition of reasonable charges,[4] in addition to the 20% of reasonable charges copayment.

Home health services are covered by Part A and Part B Medicare. However, if a beneficiary has both parts, this service will always be covered under Part A. Home health benefits require no deductibles or copayments of Part A or Part B beneficiaries. For Part A only or Part A and B beneficiaries home health may be covered as long as skilled nursing or therapy services are needed by the patient.

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4 The only exception to this is if a physician or other health professional accepts "assignment" of the Medicare benefits, meaning acceptance of direct payment from Medicare. In this case, the professional must accept the Medicare payment plus the 20% copayment as payment in full.

The Medicare program has succeeded to some degree in protecting the aged population from extensive financial losses attributable to medical expenses. However, with the program's deductibles, copayments, and benefit limitations, Medicare beneficiaries are still at risk for costs which can be considerable. The major means of dealing with this problem has been for a beneficiary to purchase a supplemental or "wrap around" policy to cover the "gaps" in benefits in the current Medicare system. This coverage has been offered by Blue Cross/ Blue Shield plans, commercial insurers, and prepaid health plans, including health maintenance organizations.

Under the Demonstration programs and in the future under TEFRA, HCFA requires that HMOs or CMPs offer the minimum statutory Part A and Part B benefits. However, the law also requires "savings" to be returned to the Medicare beneficiary through reduced cost sharing or increased benefits above the statutory minimum. If savings do occur, HMOs with Medicare risk contracts may offer some combination of the following additional benefits:

- Coverage of all or part of the deductibles and copayments
- No limitation on hospital days
- Physician services not normally covered (e.g. physical exams, immunizations)
- Vision and hearing exams
- Prescription drugs
- Hearing aids
- Dental care
- Long term care

Each of the Demonstration HMOs offered an enhanced benefit package to Medicare beneficiaries that improved the marketability of their program. Issues related to development of a benefit package for a Medicare risk contract will be considered in succeeding sections of this document.

III. BASIC RULES AND GUIDELINES RELEVANT TO RISK CONTRACTING

The process of establishing a Medicare risk contract will be governed by a new set of regulations to be issued by the Department of Health and Human Services (DHHS) in response to TEFRA. An interested organization will have to go through the following two-step process:

1. Determination of eligibility.
2. Satisfaction of contract requirements.

An organization intent on establishing a Medicare risk contract should first consider:

- Analysis of Local Market - The HMO or competitive medical plan (CMP) should complete a marketing study that includes the number of Medicare eligibles in the local area, types of Medicare supplemental coverage available, senior citizen housing, community centers, support organizations, and publications (e.g., American Association of Retired Persons - AARP - newsletters).

- Determination of Capacity - The organization should determine that it has sufficient capacity in its physical plant (staff and group model HMOs), as well as physician and support staff to accommodate a Medicare program. Plans should be aware that Medicare beneficiaries utilize a greater volume and intensity of medical care services.

- Analysis of Advantages and Disadvantages of Medicare Risk Contracting - Plans considering this arrangement should understand its advantages and disadvantages. Issues related to assumption of risk, marketing to Medicare beneficiaries, and staffing implications should be reviewed. Section IV of this document, along with the case studies, contain discussions of these issues.

- Support of Medical Staff - The HMO's or CMP's medical staff, group, and/or contracting physicians should be advised of the plan's interest in enrolling Medicare beneficiaries, and their support for the concept should be obtained. This can be accomplished by allowing the physician leadership to participate in the decision making process.

- Approval from Board of Directors - The advantages and disadvantages of Medicare contracting should be explained to the Board, and the project pursued if it is consistent with organizational goals and objectives.

The above steps should be completed prior to contacting DHHS. This internal planning process will assist the Plan in the eligibility determination stage and contract negotiation process which will follow.

A. Eligibility Criteria

Authority for determination of eligibility for a Medicare risk contract has been delegated to the Office of Health Maintenance Organizations (OHMO) of the Bureau of Health Maintenance Organizations and Resources Development (BHMORD) within DHHS. Organizations wishing to establish Medicare cost contracts must also be determined eligible by OHMO. An organization is deemed to be eligible if it:

1. Is a federally qualified HMO in accordance with Section 1301 of the Public Health Service Act, or

2. Meets the definition of a competitive medical plan (CMP) as set forth in Section 1876(b) of the Social Security Act and Section 417.407(b) of the Code of Federal Regulations.

An HMO that is federally qualified may automatically be eligible, and may contact HCFA to apply for a Medicare risk contract, as described in the following section. The remainder of this section describes the process of applying to OHMO for eligibility determination as a competitive medical plan.

Organizations that are seeking eligibility as a CMP should contact the Division of HMO Qualification within OHMO, which is responsible for making this determination. OHMO staff will send the interested organization a information package on Medicare contracting, including a copy of the relevant statutes, regulations, and an application form.

In order to be eligible for a Medicare contract, a CMP must provide a package of services (at least inpatient hospital,[5] physician, laboratory, X-ray, emergency, and preventive services, as well as out-of-area coverage) to an enrolled population on a prepaid basis. A CMP may be an HMO that is not federally qualified, but it can also be another type of prepaid health plan. The plan must provide physician services primarily through physicians who are on staff or under contract (either individually or in groups). Finally, the plan must assume full financial risk, except for certain provisions for reinsurance and transfer of risk to providers.

In order to be determined eligible, a CMP will initially have to complete an application and send it to OHMO. The applicant will have to provide background information on the plan, and demonstrate that statutory and regulatory requirements for CMPs are satisfied. For example, the organization will have to show that it is financially viable, that it protects its enrollees from liability in the event of insolvency, and that the above health services delivery criteria are satisfied.

Following submission of an application, OHMO staff will conduct a site visit to the applicant as part of its review process. OHMO will certify to HCFA that a CMP meets the eligibility requirements of the law. Determination of eligibility allows the CMP to proceed to the next step, which is the application to HCFA for a Medicare risk contract.

B. Process of Establishing a Medicare Risk Contract

In order to secure a Medicare risk contract, an eligible organization must apply to HCFA. An eligible organization should contact their regional HCFA office in order to begin the process. HCFA's Associate Regional Administrator for Program Operations will serve as the plan's

5 Entities which established Medicaid risk contracts with a State Medicaid Agency prior to 1970 that did not include provision of inpatient hospital services may be eligible without providing these services.

contracting officer. He/she will facilitate the application process leading to execution of a contract if the applicant satisfies HCFA's contracting requirements. For federally qualified HMOs, the application to the Regional Administrator for Program Operations is the only step necessary to establish a Medicare risk contract. For CMPs, this step will follow eligibility determination by OHMO, and where feasible, information already submitted to OHMO will not be requested again.

The contracting officer will request that the plan submit a set of supporting information. The required supporting material includes data on the plan's organizational and legal entity, administrative systems, service area, current membership, proposed benefits, delivery system, and financial accounting and reporting systems. Also, in order to establish a Medicare risk contract, a plan must show that:

- It has at least 5,000 members (or at least 1,500 members if the Plan primarily serves a rural area, as defined in the regulations).
- No more than 50% of its enrolled members are eligible for benefits under Medicare or Medicaid combined.
- The plan will enroll Medicare beneficiaries on a first-come, first-served basis during at least one annual 30-day open enrollment period.
- If the plan has a cost reimbursement contract, there is a equitable plan for one cost contract enrollee to switch to the risk contract for every two new risk contract enrollees.
- The plan can bear the risk of potential losses from this contract.

A very important part of this process will be calculation of an adjusted community rate (ACR). This process is described in detail in Section IV.A. on financial management of a Medicare risk contract. An ACR must be submitted by the plan and approved by HCFA prior to execution of a contract.

Following submission of an application, HCFA will assemble a team to do an on-site review of the plan's capability to implement a Medicare risk contract. Participants from HCFA on the site visit team are usually

the contract officer from the regional office, and a systems analyst and accountant from HCFA's Group Health Plan Operations (GHPO) office in Baltimore, Maryland. These individuals will help orient plan staff to the risk program. Issues related to calculation of an ACR, or HCFA's rate of payment to the Plan (95% of AAPCC) can be addressed by the HCFA staff.

During the site visit, the team will brief HMO or CMP staff on operational aspects of the Medicare risk contract. HMO/CMP staff will be oriented to membership and accretion/deletion processing, membership reconciliation, and payment procedures under the risk contract. The team will work with the plan's financial staff to ensure that the management information system is capable of generating cost and utilization data to support an ACR calculation. Finally, the team will conduct an overall review of HCFA's qualifying conditions for Medicare risk contracting as stated previously.

The process of implementing a Medicare contract with HCFA historically has taken four to six months. Prior to the site visit, in order to ensure that implementation is as timely as possible, Plan staff should be familiar with the basic requirements of the Medicare program, including the Medicare benefit package, the concept of the adjusted average per capita cost (AAPCC), and other issues discussed in this document. It is also recommended the plan prepare draft marketing materials which are available at the time of the site visit.

Following their visit, participants on the site visit team prepare a report with a recommendation on whether or not HCFA should contract with the HMO/CMP. If the report is positive, contracts are sent to the HMO/CMP for the necessary signatures. Marketing materials to be used for the Medicare program must be approved by HCFA prior to their use. At this point, the Plan is ready to begin operations under its Medicare risk contract.

IV. OPERATIONAL ASPECTS OF MEDICARE RISK CONTRACTING

Due to the age and health status of Medicare beneficiaries, the inherent risk of serving this population on a prepaid basis is greater than the risk associated with enrolling commercial groups. Medicare beneficiaries require a greater volume and intensity of service than other demographic groups served by the HMO. Therefore, it is important that the HMO take a conservative, yet realistic, approach to estimating its costs under a Medicare risk contract. Careful attention should be paid to crafting a benefit package, determining a beneficiary premium, assessing plan capacity and staffing needs, and modifying utilization control procedures.

HMOs that establish Medicare risk contracts under TEFRA have a major advantage --- they can learn from the experiences of their predecessors in the Demonstration programs. An initial round of HMO Medicare Demonstrations were held in several different types of communities: two were in major urban areas (Minneapolis and Portland), two were in mid-sized cities (Worcester, Massachusetts and Lansing, Michigan), and one was in a rural area (Marshfield, Wisconsin). More demonstrations followed the Medicare HMO Capitation Demonstration Program which began in 1978. The Medicare Competition Demonstration program began in 1982 and included tests of varying types of contractual arrangements such as regional risk pools, IPA models and so forth. Many of these latter demonstrations are currently in operation or development increasing the number of Medicare Competition Demonstrations to more than 40 plans. It was the experience of earlier demonstrations that inspired Congress to incorporate the altered risk-based payment arrangements for HMOs and CMPs into the TEFRA legislation.

This review of operational aspects of Medicare risk contracting will be divided into the following functional areas:

- Financial Management
- Marketing Management
- Health Care Delivery
- Contract Administration

In each area of HMO operations, key issues related to Medicare risk contracting will be discussed, along with notable examples of how these issues were discovered, confronted, and to a large extent resolved by selected HMO Demonstrations.

A. Financial Management

Medicare risk contracting should be considered by an HMO as a new line of business. Some of the financial questions that need to be resolved prior to establishing a contract include the following:

- Does this program support overall corporate objectives?
- Will a Medicare risk contract enhance the organization's financial viability?
- What are the incremental costs and revenues associated with this program?

Revenues from a Medicare risk contract come from two principal sources: HCFA and the Medicare beneficiary.[6] HCFA's prospective payment to an HMO will be 95% of the adjusted average per capita cost (AAPCC), and savings sharing requirements must be satisfied. In addition, the HMO may charge a premium to the beneficiary to compensate for benefits added to the HMO package above standard Medicare Part A and B coverage or to cover Medicare deductibles, coinsurances and copayments. This premium is a very important source of additional revenue. However, in order to ensure that the Medicare package being offered is marketable, it is important to assess the price elasticity of the premium. This issue will be discussed in greater detail in the marketing management section and in the Demonstration experiences summaries, particularly that of the Greater Marshfield Community Health Plan.

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6 Modest income may be obtained from coordination of benefits as well. Under TEFRA, working people aged 65-69 receive primary coverage from their employers. Reinsurance income will not be considered; rather, it will be shown as an expense net of income.

The incremental costs associated with developing a Medicare risk program are predominantly those variable cost items associated with providing medical care services to Medicare beneficiaries. At the very minimum, an HMO must ascertain that its expected revenues exceed variable costs by some "acceptable" margin, which represents the Medicare program's contribution to fixed costs and administrative overhead (the HMO reserves) . This is similar to the process that a HMO undertakes when it establishes capitation requirements and premium structure for its under 65 population.

There will, of course, be incremental fixed costs from the Medicare program as well. Medicare marketing costs and the addition of staff to market, enroll, and process claims for the Medicare program represent additional fixed costs of the program. A Plan may have to expand its existing facilities or build new facilities in order to accommodate the Medicare population. The Medicare program should incorporate a "contribution to fixed costs" that is sufficient to finance any incremental fixed costs within a reasonable payback period and contribute to the organization's overall fixed costs.

The most important determinant of the feasibility of Medicare risk contracting is whether a Plan's total capitation requirements, consisting of its costs to provide health care plus its contribution to fixed costs, translates into a premium that is marketable. The following interdependent steps are necessary in order to evaluate the feasibility and assess the financial impact of a Medicare risk contract:

1. Establish a benefit package which includes Medicare Part A and B at a minimum.
2. Determine the Plan's capitation requirement to provide that package of service.
3. Estimate an expected level of payment from HCFA.
4. Calculate the beneficiary premium.

Completing the above steps is an iterative process. A plan may complete the process and find that its premium is not competitive. The process can be repeated with a modified benefit package, perhaps resulting in a marketable premium.

1. Establishing a Benefit Package

Section 1876 of the Social Security Act requires that a contracting HMO, at a minimum, provide existing Part A and B benefits to its Medicare members. It is likely that an HMO would want to offer more comprehensive coverage than that provided by minimum Medicare benefits for the following reasons:

- The existing level of Medicare coverage leave major "gaps" in a beneficiary's health coverage which, for many people, necessitates the purchase of supplementary Medicare coverage.
- There is a heavy administrative burden and cost associated with keeping track of benefit limitations, such as days covered per "benefit period," lifetime status days, deductible payments, and coinsurance payments which fluctuate with length of stay.
- An HMO's traditional way of doing business is to provide comprehensive care in exchange for a prepaid payment.
- Marketplace competition from other insurers and/or providers of health care to Medicare beneficiaries may "dictate" that a more comprehensive benefit package be offered by the HMO.

All of the Demonstration HMOs offered enhanced benefits, and the Minneapolis sites each offered a high and low option benefit package (Note: The Minneapolis sites were permitted under the Demonstration to screen enrollment into their high option plan, but selection screening is prohibited under the new Section 1876). A summary of the benefits offered by the Demonstration HMOs is shown in Exhibit IV-1.

What level of benefits is most appropriate? A logical starting point in constructing a Medicare benefit package is the Plan's commercial benefit package. Typically, the HMO would enhance its benefits above standard Medicare coverage to include payment of Medicare deductibles

COMPARISON OF BENEFIT PACKAGES FOR MEDICARE BETWEEN STANDARD MEDICARE COVERAGE AND HMO DEMONSTRATIONS

SERVICES	MEDICARE PARTS A & B	MARSHFIELD	FALLON	HEALTH CENTRAL	KAISER/PORTLAND	INTERSTUDY (High and Low Option Plans--Differences are identified)			
						IBEW 2/	MPDCENTER 2/	NICOLLET-EITEL 2/	SHARP 2/
Inpatient Care	Part A Services $180 deductible for first 60 days; co-payment $45/day for days 61-90; $90/day for 60 lifetime reserve days.	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Low: Covered in full up to 90 days per benefit period, 60-day lifetime reserve. High: Covered in full 365 days/benefit period.	Low: Covered in full up to 90 days per benefit period, plus remaining lifetime reserve. High: Covered in full - 365 days/benefit period.	Low: Covered in full up to 90 days per benefit period, plus remaining lifetime reserve. High: Covered in full - 365 days/benefit period.	Low: Covered in full up to 90 days per benefit period, plus remaining lifetime reserve. High: Covered in full - no limit.
Outpatient Care & Physician Services									
Episodic	Part B services: $60 deductible for calendar year; 80% reasonable charges.	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Covered in full: $2 copayment per visit. $3 copayment, home visit.	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit
Lab & x-ray	Part A & B services: Part of $60 deductible for Part B and $180 for Part A.	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit	Covered in full - no limit
Emergency Care	Part B Services: $60 deductible and 80% reasonable charges.	Covered in full	Covered in full	Covered in full	Covered in full $2 copayment per visit	At plan hospital-$15 unless admitted. At non-plan--20% of first $500.	At plan hospital-$15 unless admitted. At non-plan--20% of first $500.	At plan hospital-$15 unless admitted. At non-plan--20% of first $500.	At plan hospital-$10 unless admitted. At non-plan hospital--20% of first $500.
Preventive									
1-Physical Exam	Not covered	Covered in full if related to care and treatment.	Covered in full	Covered in full	Covered in full: $2 copayment per visit	Low: not covered High: covered in full	Low: not covered High: covered in full	Low: not covered High: covered in full	Low: not covered High: covered in full
2-Immunization	Part B Services: Part of deductible & only for injury and immediate risk.	Covered in full	Covered in full	Covered in full	Covered in full (except gammaglobulin passive agents and most blood products	Low: Same as Medicare High: 100% of preventive immunizations	Low: Same as Medicare. High: 100% of preventive immunizations	Limited to direct exposure to infectious disease or injury.	100% of preventative immunizations.
3-Other	Not covered	Health education, allergy testing, hearing testing	Health education, allergy testing, hearing testing	Health education (nutrition, diabetes, hypertension, etc.)	Health education, allergy testing, hearing testing ($2 copayment).	High: hearing exams $10 copayment	High: hearing exams	High: hearing exams, allergy immunization	High: hearing exams
Skilled Nursing Care	Part A Services 20 days in full $22.50/day for days 21-100. 100 days per benefit period.	Covered in full	Covered in full up to 100 days per benefit period. 2/	Up to 100 days per benefit period. 2/	Covered in full up to 100 days per spell of illness or per yr whichever is greater	Low: 1-day hospitalization required. Up to 100 days per benefit period. High: 365 days benefit period. 1-day prior hospitalization	Low: covered in full up to 100 days per benefit period. High: covered in full, 365 days/benefit period.	Covered in full up to 100 days per benefit period.	Low: covered in full up to 100 days per benefit period. High: covered in full, 365 days/benefit period.
Home Health Care	Part A Services up to 100 visits. Part B services without prior hospitalization up to 100 visits, 80% coverage	Covered in full	Covered in full - no limit	Covered in full (includes some meal preparation)	Covered in full - no limit	Covered up to 200 visits per benefit period. No prior hospitalization needed.	Covered up to 200 visits per benefit period. No prior hospitalization needed.	Covered up to 200 visits per benefit period. No prior hospitalization needed.	Low: up to 200 visits per benefit period; High: up to 250 visits per benefit period. No prior hospitalization needed.
Private Duty Nursing	Not covered	Not covered	Covered in full		Covered in full.	High: covered in full during eligible hospital admission.	Not covered	Not covered	Not covered
Ambulance	Part B Services: 80% coverage	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	80% coverage	Covered in full
Mental Health									
Inpatient	Part A Services: $180 deductible and copayments as if an inpatient hospital above. 190 lifetime	Covered in full; 70 day maximum. Renews after discharge of 90 days.	Covered in full up to 90 days per benefit period 1/ in a psychiatric hospital and detoxification facility. General hospital stay covered in full.	Covered up to 190 days per patients lifetime in psychiatric hospital.	Covered up to 190 days per patients' lifetime	Covered up to 90 days per benefit period; 190 days in lifetime.	Covered up to 60 days in full; 61-90 days $35/day, 190 days lifetime maximum.	Covered up to 190 days in a lifetime.	Low: up to 60 days in full; 61-90 days @ $25/day. 90 days/benefit period. 190 days max. High: up to 60 days in full. 61-90 days @ $15/day. 90 days/benefit period. 190 days max.
Outpatient	Part B Services: Part of $60 deductible, but maximum of $250.	Covered in full, 20 day maximum. Renews after discontinuance of 90 days.	Covered in full for 20 visits per calendar year or $500, whichever is greater.	Covered in full for 20 visits per calendar year or up to $250 to outside provider.	Psychiatrist visits 6/year. Other health professionals unlimited. $2 copayment per visit.	Low: 80% covered up to $500 per year. High: 80% covered up to $1,000 per year.	10 visits/year at $20 visit	7 visits/yr, at $10 per visit (20 visits for chemical dependency)	Low: up to 20 visits at $10/visit. High: up to 20 visits at $5/visit.

COMPARISON OF BENEFIT PACKAGES FOR MEDICARE BETWEEN STANDARD MEDICARE COVERAGE AND HMO DEMONSTRATIONS

SERVICES	MEDICARE PARTS A & B	MARSHFIELD	FALLON	HEALTH CENTRAL	KAISER/PORTLAND*	INTERSTUDY (High and Low Option Plans--Differences are identified) IHOM 1/	MEDCENTER 1/	NICOLLET-EITEL 1/	SHARE 1/
Physical Therapy	Part A Services. Part of inpatient coverage.	Covered in full	Covered in full		Covered in full Outpatient short term therapy $2 copay/visit	Covered in full	Covered in full	Covered in full	Covered in full
Radiation Therapy	Part A Services. Part of inpatient coverage.	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Hemodialysis Services	Special coverage. Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Not covered	Not covered	Not covered	Not covered
Prescription Drugs	Part A Services: Part of inpatient coverage; Part B Services: Drugs that cannot be self-administered; 80% coverage.	Not covered	$1 copayment for drugs in plan pharmacies.		See below - Options B and D (includes $1 copayment per prescription)	Not covered	Covered with $3.50 per prescription.	Not covered	Not covered.
Eye Exam	Part B Services for eye surgery but not for eye-glasses.	Covered in full but does not include cost of frames or lenses except for cataract surgery.	Covered in full for one examination per year.	Vision screening only. Examinations are not covered.	Covered in full. $2 copayment per visit.	Low: not covered. High: covered--$15 copayment	Low: not covered. High: covered in full	Low: not covered: High: covered in full	Low: not covered. High: covered in full
Eye Glasses	Part B Services. Coverage for contact lenses for post-cataract surgery patients. No other coverage.	Coverage only for lenses for post-cataract surgery patients.	Covered in full for one set each year.	Coverage only for lenses for post-cataract surgery patients.	Low: coverage only for lenses for post-cataract surgery patients. High: see below--Options B and D.	Coverage only for lenses for post-cataract surgery patients.	Coverage only for lenses for post-cataract surgery patients.	Coverage only for lenses for post-cataract surgery patients.	Coverage only for lenses for post-cataract surgery patients.
Prosthetic Devices and Durable Medical Equipment	Part B Services for devices that are used for internal organs and artificial limbs. No dentures; 80% coverage.	Covered in full except for non-rigid appliances or supplies.	Covered in full	80% of cost of device when medically necessary.	Covered in full for Medicare covered prostheses and equipment	Covered in full	Covered in full	80% coverage	Covered in full
Dental Care	Part B Services. Only if it involves surgery of jaw or setting of fractures.	Covered only for surgery of jaw or need caused by facial fractures.	Oral surgical procedures & related x-rays. Routine care and penodontal surgery not covered.	Covered if accident-related or multiple extractions performed in hospital.	Low: covered only for surgery of jaw and related structures. High: see below--Options C and D.	Covered only for surgery of the jaw and related structures.	Covered only for surgery of the jaw and related structures.	Covered only for surgery of jaw or other related structures.	Covered only for surgery of jaw or related structure.
Chiropractor Services	Part B Services. Only coverage for manipulation of spine to correct subluxation.	Only coverage for manipulation of spine to correct subluxation when done at the clinic.	Only coverage for manipulation of spine to correct subluxation when done at the clinic.	Only coverage for manipulation of spine to correct subluxation when done at the clinic.	Not covered	Only coverage for manipulation of spine to correct subluxation when done at the clinic.	Only coverage for manipulation of spine to correct subluxation when done at the clinic.	Only coverage for manipulation of spine to correct subluxation when done at the clinic.	Only coverage for manipulation of spine to correct subluxation when done at the clinic.
Podiatrist Services	Part B Services. Coverage of all services except routine foot care.	Covered in full	Coverage except for routine foot care or supportive devices.		Not covered	Coverage except for routine foot care & supportive devices.	Coverage except for routine foot care or supportive devices.	Coverage except for routine foot care and supportive devices.	Low: coverage except for routine foot care and supportive devices. High: covered in full.
Monthly Premium Charge to Enrollees		$21.67	$7.50		Options: A - $0 B - $6 C - $9.81 D - $15.81	Low: $21.75 High: $22.05	Low: $15.75 High: $27.75	Low: $12.50 High: $16.55	Low: $13.95 High: $14.95

*KAISER/PORTLAND: The Kaiser Experiment has 4 options of coverage:
Option A: Medicare-coordinated coverage.
Option B: Medicare-coordinated coverage with additional payment for benefits of prescription drugs, eye-glasses, hearing aids.
Option C: Medicare-coordinated coverage with additional payment for dental care benefits.
Option D: Medicare-coordinated coverage with Options B and C included.

1/ Benefit periods under Fallon: Benefit period means the period of time which starts when you are admitted to a hospital or skilled nursing facility. It ends once you are out of a hospital or skilled nursing facility for 60 days in a row.

1/ Benefit periods under Health Control and Interstudy: Benefit period is synonymous with discreet episode of illness.

and copayments, elimination of limitations on inpatient hospital benefits, and payment for "routine" physician services normally excluded by Medicare. In addition, the HMO may wish to offer one or more of the following benefits:

- prescription drugs
- eyeglasses
- hearing aids
- dental care
- unlimited skilled nursing care
- long term care

Final determination of a benefit package cannot be made until the costs of providing a given benefit package are projected, these costs are compared with expected payments from HCFA, and a determination is made about the marketability of the resultant beneficiary premium. Therefore, determination of a benefit package is the first step of an iterative process.

An HMO may attach copayments to any of the supplemental benefits in its benefit package and can maintain all or part of the deductibles and/or copayments associated with standard Part A and B benefits. However, any "savings" generated by the HMO must be returned to the Medicare beneficiary through additional benefits or reduced premiums or cost-sharing. Therefore, the effect of adding or maintaining deductibles and copayments is to reduce the amount of premium that would otherwise be charged to the beneficiary (assuming a fixed benefit package). Increased cost-sharing may, on the other hand, allow a plan to offer more benefits.

Exhibit IV-2 contains a hypothetical benefit package for a HMO with a Medicare risk contract. This package is based upon an "average" package offered by the demonstration sites, and will be used throughout this section for example purposes.

EXHIBIT IV-2

MEDICARE PROGRAM BENEFIT COMPARISON

PART A

STANDARD MEDICARE BENEFITS	HYPOTHETICAL MEDICARE RISK PROGRAM
In The Hospital:	Standard Medicare Benefits Plus the Following Additional Benefits:
- Up to 90 days per benefit period - Deductible for 1st through 60th day ($356/benefit period) - Daily coinsurance for 60 life-time reserve days ($178/day)	- Payment of the current Medicare required deductible and coinsurance - Unlimited coverage of inpatient hospital days
Psychiatric Hospital	
- 190 day lifetime limit	
Skilled Nursing Facility	
- Up to 100 days per benefit period - 20 days at no charge - Daily coinsurance for 21st through 100th day ($44.50/day)	

PART B

	Standard Medicare Benefits Plus the Following Additional Benefits:
- Doctors office visits - Specialist care and consultations - Lab and x-ray services - Medical and surgical services - Electrocardiograms - Physical therapy - Urgent visits - Psychiatric care (limited to $312.50 or 6½% of reasonable charges per year, whichever is less) - Prosthetic devices - Durable medical equipment - Home health care (unlimited visits) - Covered at 80% of reasonable charge after the yearly $75 per year is met (no coinsurance requirements for home health care).	- Payment of the current Medicare required deductible and coinsurance - Physical examinations - Eye examinations - Allergy testing, allergy injections - Hearing tests - Nutrition counseling - Immunizations - Injections - Prescription drugs purchased at participating Pharmacies with $3 copayment - Eyeglasses (one paid every 2 years) - Psychiatric care (10 outpatient visits per year)

2. Determining the Plan's Capitation Requirement

Perhaps the most important step in evaluating the feasibility of a Medicare risk program is estimating the cost to the HMO of providing its predetermined package of benefits. An HMO that has not previously served Medicare beneficiaries has no plan-specific utilization data upon which to base its cost projections. The Plan must utilize outside sources of data which may not be as reliable for cost estimation purposes as internally generated information. This limitation in data represents a major difficulty in assessing the feasibility of Medicare risk contracting.

TEFRA refers to the process of determining an HMO's captitation requirement as calculating an "adjusted community rate (ACR)." For Medicare risk contractors, the primary function of the Reimbursement Branch of HCFA's Group Health Plan Operations (GHPO) is to approve the Plan's ACR calculation. For cost contracting HMOs, GHPO's primary function is to audit the Plan's cost reports. There are alternative methods of calculating an ACR, but the end product, regardless of the method used, is a summary sheet similar to the one contained in Exhibit IV-3.* Each plan must go through the following steps:

1. Establish and be able to justify its community rate relative to Medicare benefits (the "initial rate" referred to in TEFRA regulations).

2. Establish adjustment factors for volume and price differences associated with the Medicare population for each benefit category.

3. Apply ratios to the community rate in each category to get the Medicare capitation rate, or ACR.

This process, in the order described above, has been referred to as the "build-up" approach to calculating an ACR. The Plan's ACR is calculated by building up the community rate using a set of adjustment

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* As this report was written, HCFA and members of the HMO industry were continuing discussion about the format to be used for ACR calculation.

factors or ratios. The difficult part of this process is determining appropriate adjustments for volume and price associated with treatment of the Medicare population.

ANY ELIGIBLE ORGANIZATION, INC.

ADJUSTED COMMUNITY RATE (ACR) PROPOSAL

YEAR ENDING 12/31/84

SUMMARY SHEET

(AAPCC: Part A = $114.97; Part B = $59.70; Total = $174.67)

ELEMENT	COMMUNITY PMPM	ADJUSTMENTS VOLUME	PRICE	ACR - PMPM
1)INPATIENT HOSPITAL	$19.00	4.25	.95	$ 76.71
2)OUTPATIENT HOSPITAL	2.00	3.00	1.10	6.60
3)PHYSICIAN SERVICES	20.00	2.25	1.10	49.50
4)OTHER MEDICAL SERVICES	4.00	2.50	1.20	12.00
5)HOME HEALTH SERVICES	.20	10.00	1.20	2.40
6)SKILLED NURSING SERVICES	.25	6.00	1.00	1.50
7)EMERGENCY SERVICES	.30	2.00	1.00	.60
8)AMBULANCE SERVICES	.15	3.00	1.00	.45
9)OTHER SERVICES	2.00	1.50	1.00	3.00
10)PLAN ADMINISTRATION	6.55	--	--	9.75
11)NON-MEDICARE SERVICES	(11.00)	--	--	--
12)ENROLLEE LIABILITIES	(3.00)	2.25	1.00	(6.75)
13)GROSS PREMIUM				155.76
14)LESS ADJUSTMENTS:				
COORDINATED BENEFITS	(1.00)	.50	--	(.50)
MEDICARE DEDUCTIBLE/ COINSURANCE	--	--	--	(30.82)
MEMBERS WITHOUT PART A	--	--	--	(.16)
15)SUBTOTALS - ACR	$39.45*	--	--	$124.28**
16)95% OF AAPCC				165.94
17)LESS LINE 15 (ADJUSTED COMMUNITY RATE)				124.28
18)DIFFERENCE TO MEDICARE OF MEMBERS				41.66
19)SUPPLEMENTAL BENEFITS:				
MEDICATE DEDUCTIBLE & COINSURANCE (LINE 14)				30.82
IMMUNIZATIONS & PREVENTIVE SERVICES				3.50
OUTPATIENT DRUGS				15.00
EYEGLASSES				2.49
TOTAL				$51.81
20)PREMIUM TO MEDICARE RISK MEMBER				$10.15
21)RETURN TO GOVERNMENT				$ 0.00

* The "initial rate " - hypothetical rate that would be charged to non-Medicare HMO members for Medicare benefits.

** The Adjusted Community Rate (ACR)

An HMO that has not previously served Medicare beneficiaries (or only served them on a cost basis) must borrow data from external sources. There is, however, a potential danger that the ratios may not be applicable to the situation where they are being applied. An example of where this occured is at the Fallon Community Health Plan (FCHP) in the first year of their Demonstration.

When FCHP began its demonstration in April 1980, it had no previous utilization experience on which to base its ACR calculation. FCHP chose to use data on the Medicare population served by Kaiser-Permanente of Northern California. At the time, the most recent figures available from Kaiser (1977) showed an "under 65" hospital utilization rate of 372 days per 1000 members, and an "over 65" rate of 1677 per thousand, representing a volume adjustment of 4.51 to 1. FCHP was anticipating its own under 65 hospital utilization rate for 1980 to be 510 days per 1000. Using Kaiser's volume factor, FCHP projected its hospital utilization for the first year of the Demonstration at 510 x 4.51 or 2300 days. At the time, Part A utilization (including SNF days) for Worcester County, was approximately 4500 days per 1000.

FCHP's actual hospital utilization rate in the first year of the Demonstration was approximately 2650 days per 1000. This is a satisfactory level of utilization in light of local utilization experience in the fee-for-service sector and FCHP's lack of previous experience in Medicare risk contracting. However, due to the fact that FCHP's prospective payment was based upon 2300 days per 1000, the Plan's hospitalization expense was significantly over budget in the first year.[7] FCHP's hospital utilization projections were unrealistically low. Kaiser's adjustment factors did not take into account those local factors influencing hospital use at FCHP, including population characteristics, medical practice patterns, and differences in utilization controls. The

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7 This situation reversed itself dramatically in future years as FCHP's predictions became more accurate (using the Plan's actual experience) and an excellent utilization control effort was launched (see FCHP case study, Section V).

lesson to be learned from the Fallon experience is that cost and utilization projections must incorporate local factors, whether the approach to ACR calculations is the "build-up" approach or some other method.

Health Central in Lansing, Michigan used actuarial first principles to establish its ACR. The Plan had not previously served Medicare beneficiaries, but used adjusted local data. Health Central started their Demonstration over a year after the beginning of the Fallon, Marshfield, and Kaiser Demonstrations. With the benefit of experience learned from these other Plans, Health Central made conservative projections which contributed to favorable financial results for the program in Year 1.

Returning to Exhibit IV-3, each line item in an HMO's ACR calculation should be supported by a back-up sheet which shows the derivation of the ACR values and indicates how the adjustment factors were calculated. Illustrative backup sheets for hospitalization and home health services are shown in Exhibit IV-4.

The ACR calculation also involves calculation of a series of offsets for the following:

- Copayments - Copayments are shown on line 12 of Exhibit IV-3 as "enrollee liabilities." In this example, copayments are applied to physician services, so the community rate value is multiplied by a 2.25 volume factor, the same as the factor used to adjust the cost of physician services (line 3).

- Coordination of Benefits - The opportunity for coordinating benefits may be less for the Medicare population compared with a commercial population. This assumption was used to estimate a volume adjustment of .5.

- Medicare deductibles and coinsurance - offsets for Medicare deductibles and copayments, and members without Part A, may be calculated or can be estimated by HCFA. Once again, backup sheets should be provided.

Exhibit IV-4

ILLUSTRATIVE BACKUP SHEET - HOSPITALIZATION

	UTILIZATION*		COST**	
	COMMUNITY	MEDICARE	COMMUNITY	MEDICARE
SURGICAL/MEDICAL	230	1905	$598.82	$476.65
PEDIATRIC	30	--	650.40	--
PSYCHIATRIC	30	50	275.00	250.00
OBSTETRICAL	80	--	500.00	--
NEWBORN	90	--	250.00	--
	460	1955	495.63	470.85

* DAYS PER 1000/YEAR - RELATIVE WEIGHTS FOR MEDICARE BASED ON EXPERIENCE OF THIS PLAN FOR PERIOD 1975-82 - SEE EXHIBIT

** PER BED DAY - AVERAGE CHARGES PAID IN YEAR ENDED 12/31/82 INFLATED AT 15% PER YEAR TO MIDPOINT OF YEAR ENDED 12/31/84.

ILLUSTRATIVE BACKUP SHEET - HOME HEALTH SERVICES

	UTILIZATION* COMMUNITY	UTILIZATION* MEDICARE	COST** COMMUNITY	COST** MEDICARE
CONTRACTED VISITING NURSE SERVICE	48	480	$50	$60

* PER 1000 MEMBERS PER YEAR - MEDICARE UTILIZATION AS INDICATED IN HEALTH CARE FINANCING NOTES - MEDICARE - USE OF HOME HEALTH SERVICES, 1979 (TABLE 2) WITH AGE ADJUSTMENT PER HEALTH CARE FINANCING PROGRAM STATISTICS - MEDICARE: USE OF HOME HEALTH SERVICE, 1977 (TABLE 6) AND AREA ADJUSTMENT PER IBID, (TABLE 4).

** PER AVERAGE UNIT OF SERVICE - PER QUOTATION FROM VNA

One aspect of the ACR calculation that is of utmost concern to HMOs involved in Medicare risk contracting is the contribution to fixed costs (reserves) and administrative overhead that must be built into the Plan's capitation requirements. This is line 10 on Exhibit IV-3, "Plan Administration." In the example contained in Exhibit IV-3, the community rate contribution to plan administration is $6.55 out of a total of $39.45, or 16.6% (Note: this is after services not covered by Medicare, but provided in the Plan's regular benefit package, have been taken out).**

The plan's adjusted community rate is represented by line 15 in Exhibit IV-3. This is the cost to the HMO of providing only Medicare covered benefits to enrolled beneficiaries. This number is compared with HCFA payments to the HMO, which are equal to 95% of the AAPCC (lines 16 and 17, Exhibit IV-3). A description of how to estimate AAPCC is contained in the following section of this report.

Section 1876 provides that under a Medicare risk contract, if the ACR is less than the average of the per capita rates of payment to be made, then the HMO shall provide "additional benefits" (selected by the HMO) at least equal to the difference between ACR and the expected level of payment. Additional benefits may take the form of health benefits not normally covered by Medicare, and/or the reduction in premium rates or other charges that would otherwise be assessed for these additional benefits. Alternatively, the HMO may elect to receive a lesser payment from HCFA (below 95% of AAPCC) to the extent that there is no longer a difference between ACR and the HCFA payment.

** As of the writing of this paper, the proposed regulations do not address the allowed contribution to administration within the ACR nor have any policy decisions been made on this issue.

In the example in Exhibit IV-3, this HMO has chosen to add the following benefits at a total cost to the plan of $51.81 per member per month.

	Benefits	Cost
1.	Coverage of Medicare deductibles and copayments	$30.82
2.	Immunization's and preventive services	3.50
3.	Outpatient prescription drugs	15.00
4.	Eyeglasses	2.49
		$51.81

Therefore, in order to satisfy the requirement that savings from a Medicare risk contract be returned to the Medicare, the above benefits will be added to the risk contract package and the associated cost to the beneficiary will be reduced by $41.66, the difference between ACR and HCFA's projected payment. The HMO receives the full 95% of AAPCC and no money is "returned to the government." The premium charged to the beneficiary is the difference between the full cost of the additional benefits ($51.81) and the amount of "savings" available to fund additional benefits ($41.66), or $10.15.

New Medicare risk contractors that have existing cost contracts have another option with respect to this "savings sharing" requirement. All new Medicare enrollees in the HMO must enroll under the risk contract. The new law, however, will allow only one existing cost contract enrollee to switch from the cost program to the risk program for every two new enrollees in the HMO under the risk contract. Therefore, Plans with existing cost contracts will have to operate with two reimbursement techniques for a period of time. The HMO may share savings from the risk contract with its risk contract enrollees only or, at its own option, the HMO may spread the savings among cost contract enrollees as well who sign an agreement to be "locked-in" to the HMO, even though they are being served under a cost contract. This strategy should be considered by an HMO. It may be advantageous in that the HMO's cost contract enrollees are "locked-in" and the HMO's volume of business will increase.

In order to make its calculations related to savings, a plan must be able to estimate its expected payments from HCFA. In the following section, the concept of adjusted average per capita cost will be defined, its methodology for calculation reviewed, and a technique for estimating payments presented.

3. Estimating Payments From HCFA

Plans which establish Medicare risk contracts will be paid 95% of the "adjusted average per capita cost (AAPCC)" a concept developed in recent years by HCFA actuaries as the basis for reimbursement of HMOs on a risk basis. AAPCC is an estimate of what it would have cost HCFA if those Medicare beneficiaries enrolled in an HMO had received their medical care in the fee-for-service sector. The exact level of payment is based upon the AAPCC for the counties of the HMO's service area, and reflects the specific enrollment mix (by county, age, sex, institutional and welfare status) of the Medicare beneficiaries who enroll in the HMO.

In practice, AAPCC is developed in the following manner:

1. Calculation of national average per capita costs - using the most recent data available, HCFA actuaries will determine the average level of expenditure for all Medicare eligibles. A separate calculation will be made for the Medicare aged and Medicare disabled populations, and for Part A and Part B services within each beneficiary category.

2. Calculation of area per capita costs - this is a geographic adjustment whereby the ratio of county per capita costs to national per capita costs is calculated. The ratio used in AAPCC calculations is a 5 year average. Since there is a two year time lag for accumulation of data at the county level, the geographic adjustment is based at least partially upon data from as many as seven years prior to the year in question.

3. Calculation of age-sex underwriting indices - the area per capita cost is adjusted to reflect the specific enrollment mix of the HMO. Adjustments are made for the following underwriting factors: age, sex, institutional status, and welfare status. "Institutional" status is defined by HCFA actuaries as accruing to those who are confined in an institution other than a short-stay hospital for a period of thirty or more days. Welfare status is defined as being eligible for Medi-

caid, as determined usually by whether the state Medicaid agency has exercised its "buy-in" option. A state Medicaid agency will usually pay the beneficiary's Part B premium (i.e., "buy in") when the individual is also eligible for Medicare, in order to reduce the state's costs. These underwriting indices are calculated separately for Part A and B benefits, and for the aged and disabled populations.

4. Calculation of AAPCC Ratebook - Once the above calculations are made, a "ratebook" is established for each county from which beneficiaries enroll. Separate calculations are made from Part A and B benefits, and for the aged and disabled populations. When the age, sex, welfare and institutional status underwriting indices are applied, 120 "rate cells" are generated. Rates are calculated for each of the 120 cells based upon the anticipated deviation from the average cost per beneficiary in the county.

Once the ratebook has been established, HCFA payments are made at 95% of AAPCC. The actual distribution of Medicare beneficiaries enrolled in the plan, corresponding to cells in the ratebook, will determine the final level of payment by HCFA. If the projected rates prove to be an accurate reflection of costs to HCFA, then the government will automatically save 5% of the cost of Part A and B services for the average beneficiary enrolling in the demonstration.

Therefore, in order to evaluate the financial viability of risk contracting, the HMO must estimate its expected level of payment from HCFA. The simplest way to do this is to calculate an average per capita cost (APC) for each county from which the HMO will generate enrollment. The APC for each county is the expected level of payment from HCFA, not adjusted for age, sex, institutional and welfare status. Therefore, if an HMO enrolls a population that is demographically the same as the overall Medicare population in a given county, its payment level will be approximately 95% of APC. Calculation of an APC is a relatively simple process, and it a useful estimate of the expected payment from HCFA. The following steps should be undertaken:

1. The HMO must obtain cost data for Medicare Parts A and B, and for the aged and disabled populations, at the county level (the "geographic index") for the most recent five-year period. The geographic index, which compares costs in each county to the national average, is computed by HCFA's Office

of Financial and Actuarial Analysis. For an estimate of AAPCC in 1984, geographic indices from 1977 through 1981 are needed. An example for Sacramento County is shown below.

Ratio of County Per Capita Cost to National Per Capita Cost	1977	1978	1979	1980	1981	5-Year Average
Part A - Aged	.940	.893	.911	.972	.986	.940
Part A - Disabled	.959	.961	1.007	1.013	1.020	.992
Part B - Aged	1.237	1.260	1.412	1.246	1.198	1.271
Part B - Disabled	1.510	1.392	1.582	1.386	1.305	1.435

2. Once the geographic indices have been obtained for 5 years, these numbers should be averaged, as shown on the far right column above. This number should be multiplied by the United States per capita cost (USPCC), as shown below.

	1984 USPCC	County Adjustment	Area Per Capita Cost
Part A - Aged	$126.85	.940	$119.24
Part A - Disabled	$136.79	.992	$135.70
Part B - Aged	$58.26	1.271	$74.05
Part B - Disabled	$75.53	1.435	$108.39

3. The Part A and B costs should be summed to yield an average cost for each Aged and each Disabled Medicare beneficiary. The plan's expected payment is 95% of this amount. Shown below is the average per capita costs (APC) and 95% of APC for Sacramento County. If an HMO has more than one county in its service area, the above steps are taken for each county.

	Area Per Capita Cost (APC)	95% of APC
Aged	$193.29	$183.63
Disabled	$244.09	$231.89

4. The final step in calculating the expected level of payment from HCFA is to determine the expected distribution of enrolled members among the aged and disabled categories, and take a weighted average. If more than one county is involved, the distribution by county should also be taken into account. In the above example, assume that 95% of the HMO enrollees will be aged Medicare beneficiaries, and 5% will be disabled. Therefore the expected payment from HCFA is as follows:

% Distribution of Eligibles	Eligibility Class	Estimated 1984 95% of APC		Weighted Averaged
95	Aged	$183.63		$174.45
5	Disabled	$231.89		11.59
			Total	$186.04

Based upon the above methodology, this plan can expect a level of payment from HCFA of around $186.04. However, this figure represents 95% of the average per capita cost in Sacramento County, not yet adjusted for age, sex, institutional status, and welfare status. To the extent that an HMO enrolls a population that is demographically similar to the population at large in the County, it should receive a monthly payment of $186.04. To the extent that the demographic characteristics differ from the county "average", HCFA's level of payment to the HMO will be adjusted slightly up or down from $186.04. For estimation purposes prior to initiating a Medicare risk contract, this is a good estimate which may be used in preparing a benefit package and calculating a beneficiary premium. Some further adjustments can be made to reflect the expected demographic characteristics of the Plan's enrolled population.

4. Calculating The Beneficiary Premium

Once the HMO has established its total capitation requirements for the Medicare Program (adjusted community rate plus the cost of providing additional benefits), the process of calculating the beneficiary premium is one of simple subtraction. The beneficiary premium is equal to the Plan's total capitation requirement less its expected level of payment from HCFA. In the example in Exhibit IV-3, the Plan needs $176.09 per beneficiary per month to provide the benefits shown. Since the plan expects to receive $165.94 from HCFA (95% of AAPCC), the plan will charge the beneficiary a monthly premium of $10.15. Under the new Medicare law, these numbers must add up. If the HMO's capitation requirements are less than 95% of AAPCC, the Plan must accept less than 95% of AAPCC unless the Plan adds benefits which bring its expected costs above HCFA's maximum payment level. It is expected that most HMOs would want to offer a benefit package that

had a capitation requirement of at least 95% of AAPCC. To do otherwise would be "leaving money on the table."

The above summarizes the major steps in assessing the financial viability of Medicare risk contracting. This process must be undertaken prior to establishing such a contract. The Reimbursement Branch of GHPO will serve in an advisory role to HMOs that are completing this financial assessment, and they must approve the ACR calculations prepared by a Medicare risk contractor prior to each contract year. A thorough understanding of the above process is essential to the effective financial management of a Medicare risk contract. Other financial issues will be reviewed below.

5. Approaches to the Assumption of Risk

The inherent risk of providing services to Medicare beneficiaries on a prepaid basis is considerably greater than that associated with serving other population groups. The HMO demonstration experience indicates that Medicare beneficiaries typically use over four times as many inpatient hospital days as the HMO's commercial population; outpatient utilization increases on the order of two times as much. An HMO considering Medicare risk contracting for the first time would reasonably want to consider all of its options for reducing or sharing risk. These options will be presented through examples of the techniques used by the HMO Demonstrations. Following are the major risk limitation procedures used at each of the Demonstration sites:

1. Fallon.

- o FCHP purchased four types of reinsurance -- aggregate stop-loss related to hospital utilization rate, individual stop-loss, insolvency, and out-of-area utilization. Total premium was $3.35 pmpm, about 2.6% of total cost.
- o The Fallon Clinic agreed to a prospective capitation rate for all primary and specialty referral care, with the exception of sub-specialty care not available at the Clinic. This protected Fallon Community Health Plan from risk related to these benefits.

- The first year rate development included an allowance of $2.23 pmpm (about 1.8% of total cost pmpm) for "threshold physician" costs. This was the cost attributed to paying full salaries for new staff physicians who would initially not be fully utilized.

2. Marshfield.

- Like Fallon, Marshfield had a capitation agreement with its affiliated medical group.

- Marshfield also had per diem rate agreements with the three hospitals in the area, limiting the risk associated with hospital cost to utilization rates.

- Marshfield had a capitation arrangement--in effect, a reinsurance agreement--with Wisconsin Blue Cross/Blue Shield, covering emergency and out of plan referral services and administrative services. For the first year the capitation rate was $7.74 pmpm, about 8.1% of total projected cost. In the second year of operations, this capitation was $11.22 (11.2% of projected cost).

- Beginning in fiscal year 1982 for Marshfield the 17th month of the Demonstration, HCFA agreed to a risk sharing formula to partially offset losses to the Plan for inpatient hospital utilization above budgeted amounts. The level of HCFA's participation in this loss sharing arrangement varied according to the number of inpatient hospital days utilized by Marshfield over the budgeted amount (see Marshfield summary, Section V, for greater detail).

3. Kaiser.

- Similar to Fallon and Marshfield, Kaiser limited its risk for the cost of professional services by capitating its medical group.

- Kaiser's initial cost projections resulted in a cost pmpm less than the 95% of AAPCC available from HCFA. Kaiser had proposed that any difference between ACR and 95% of AAPCC be placed in a benefit stabilization fund (BSF), so $3.38 in the first year, about 3.5% of the HCFA capitation, was placed in a BSF. The BSF was a reserve account that could be drawn upon in future time periods, if the relationship between per capita cost and HCFA capitation did not continue to be favorable.

4. Health Central is a staff model HMO, and therefore is unable to transfer any risk to a corporate physicians' entity. Health Central's rate development, however, included a figure of $6.42 pmpm designated for reserves, derived from actuarial analysis of the probability of plan expenses from the Medicare program exceeding budgeted expenses by varying percentage amounts. This figure represents about 5% of the total projected cost and about 5.8% of the HCFA capitation.

5. HCFA permitted the Twin Cities HMO Demonstrations to screen applicants for their high option plans on the basis of health status. However, all applicants for the low option plans, including applicants for the high option plans who did not pass the screen, had to be accepted during a 30-day open enrollment period held once a year. This underwriting practice is common to the indemnity insurance industry, but is prohibited by Section 1876 under TEFRA and was prohibited at the other Demonstration sites.

The above examples illustrate the range of approaches used to limit risk by the HMO Demonstrations. Certain of these strategies were permissable only through special Demonstration waivers from the Social Security Act. For example, the health screening activities of the Minneapolis HMOs and the risk sharing arrangements with HCFA that allowed for payment above 95% of AAPCC at Marshfield and Health Central[8] were special provisions of the Demonstration. Future Medicare risk contracts under Section 1876 will not permit underwriting or risk sharing with HCFA, but strategies for limiting risk may include purchase of reinsurance, transfer of risk through capitation contracts with provider entities, and calculation of reserves into the ACR. Current regulation on the methodology for calculating ACR will limit the amount of reserves that may be accumulated by the HMO. This issue is discussed below, to the extent that reserves are a part of the "contribution" to fixed cost calculated into the adjusted community rate.

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8 Actual payment above 95% of AAPCC took place only in the case of Marshfield.

6. Limitations on Rate of Return or Contribution to Fixed Costs

In order to be a financially viable line of business, revenues received from a Medicare risk contract must at least cover the variable costs of serving Medicare beneficiaries, and provide enough additional money to contribute to the plan's overhead expenses, administrative and marketing cost, and other fixed costs. If it is a proprietary organization, the program should provide some rate of return to the shareholders of the organization. Any reserves that a plan wishes to incorporate into its ACR calculation must also be included as part of this contribution.

HCFA guidelines on this issue indicate that the magnitude of the contribution from the Medicare program cannot exceed the same percentage contribution calculated into a plan's community rate. TEFRA has established the principle that the premium structure which exists in the overall marketplace should prevail for Medicare. If a plan has a very small contribution to fixed costs in its community rate, then a maximum of the same percentage contribution may apply to Medicare. The effect is that a plan may not make windfall profits at the expense of the Medicare program. On the other hand, an HMO with a large contribution factored into its community rate may do the same for Medicare. In this way, the Medicare Program will parallel the market trends in terms of its contribution or rate of return for that particular HMO.

7. HCFA Auditing Function

Responsibility for monitoring the payments made under Medicare risk contracts will be the responsibility of Group Health Plan Operations (GHPO) of HCFA. The primary role of GHPO is consistent with the prospective nature of the payments made to participating plans, which is to make final approval of prospective ACR calculations submitted by

the Plans. Other services that may be provided by GHPO include serving in a technical advisory role in preparation of a ACR, providing assistance in estimating Medicare deductibles and copayments, and ensuring that savings are returned to the beneficiary.

There will be no retrospective review per se of the HMO's costs to provide service under a risk contract, as would take place if the Plan had a Medicare cost contract. However, the ACR calculations must be resubmitted each year, and approval of the ACR after the first year of the risk contract will take into account actual operating performance in previous years.

It is interesting to note that in cases where an HMO is operating both a Medicare cost and a risk contract,[9] GHPO will be responsible for approving the Plan's ACR calculation as well as doing a retrospective audit of costs under the cost contract. The cost contract audit will, albeit unintentionally, provide HCFA with additional information for the process of approving the ACR.

Several additional financial issues are discussed in the marketing, health care delivery, and administration sections that follow. For example, how will the scope and sophistication of an HMO's utilization controls affect the financial projections developed above? Since HCFA is paying an HMO at 95% of its average cost, does the Plan have the option of paying its providers, most importantly its hospitals, at HCFA's allowable cost rates? These and other related financial issues are discussed below.

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9 An HMO with an existing cost contract may simultaneously operate a Medicare cost and risk contract. The HMO may establish a risk contract, and then transfer one cost contract enrollee to the risk contract for every 2 new risk contract enrollees.

B. Marketing Management

The marketing of a prepaid health plan to Medicare beneficiaries presents some new and unique problems for both the Plan and the beneficiary. Medicare marketing focuses on individuals, in contrast to the group marketing that characterizes the commercial marketplace. Under Section 1876 of the Social Security Act, HMO risk contractors must, at a minimum, have a 30-day annual open enrollment period. The opposite extreme would be continous open enrollment for Medicare beneficiaries. A Medicare beneficiary may disenroll to re-enter the fee-for-service sector at any time. Medicare beneficiaries must be made familiar with the HMO concept and its requirement that a member use only plan providers. The approach to marketing chosen by an HMO influences enrollee understanding of the system, and can be an important determinant of the financial success of the Medicare program.

The Fallon Community Health Plan (FCHP), which was the first Demonstration to become operational, had an early goal of enrolling "big numbers", according to their Marketing Director. Since FCHP is a Blue Cross affiliate, the Plan was able to market its Medicare program, called "Senior Plan," on a dual choice basis to all existing subscribers to the Blue Cross Medicare Supplemental Plan. All Blue Cross subscribers residing in FCHP's service area were sent a Senior Plan brochure and enrollment application.

FCHP succeeded in enrolling 5300 Medicare members in the first nine months of the Demonstration, but at the expense of some major problems. There were a disproportionate number of errors among the completed applications, which resulted in processing delays and confusion about the effective date of coverage. In addition, FCHP staff report a poor understanding of the program (e.g., the "lock-in") among many people who enrolled by mail.

Since the development of these problems related to understanding the delivery system, FCHP launched a major educational effort targeted at the Senior Plan members. FCHP developed the following approaches

to educating and orienting their members. New Medicare risk contractors may wish to incorporate these characteristics into their programs prior to going operational.

1. Enrollment in person - After the first year of the Demonstration, FCHP stopped accepting enrollment applications through the mail. Enrollees were required to sign up in person, either at a presentation made by FCHP representatives or at the Plan offices. This ensures that the potential member has been given an adequate explanation of the program. Office of Demonstration Evaluations (ODE) will allow a plan to enroll only in person, but under such circumstances, the plan must agree to send a representative to the home of a non-ambulatory Medicare beneficiary who requests information or wishes to enroll in the Plan.

2. Identification Cardholder - FCHP found that there was a great deal of confusion in the use of the Medicare card by enrollees due to the lack of understanding on how to use the system. FCHP designed a special holder for both the Fallon membership card and the Medicare card, with instructions to hospitals and physicians on payment procedures for the Demonstration. The cardholder also serves as an educational tool for the Medicare beneficiaries. The ID cardholder is described in a letter to Senior Plan members contained in Appendix B.

3. Special Senior Plan Publications -FCHP published "Just a Friendly Reminder," (see Appendix C) which explained the lock-in to Senior Plan members. In addition, FCHP developed "Senior Spotlight" (shown in Appendix D), a newsletter published especially for Senior Plan members.

4. Senior Plan Advisory Committee - This is a group of eight volunteers who represent a cross-section of Senior Plan enrollment. This group meets monthly to discuss issues relevant to the Senior Plan. The Committee is often used like a focus group which reviews, for example, new marketing brochures for Senior Plan. Fallon staff strongly recommend this type of program for new risk-type Medicare plans.

These activities used by FCHP help support the orientation/education function that is crucial to a Medicare program. The Fallon experience indicates that accepting enrollment by mail can create a serious orientation problem. An alternative to the above approach for an HMO that wants to permit enrollment by mail is to set up a telephone bank so that applications received by mail can be followed-up by telephone. The purpose of the telephone call is to verify the accuracy

of the information on the application and explain the lock-in. This approach may result in cancellation of applications by those Medicare beneficiaries who did not understand the program. However, the plan is likely to avoid many of the problems encountered by FCHP due to a members' misunderstanding of the system.

Kaiser-Portland is another HMO Demonstation site that accepted applications by mail and experienced utilization problems, primarily greater-than-expected volume of non-emergency out-of-plan claims. This use resulted in financial losses to the Plan in the first ten months of the Demonstration. Initially, Kaiser adopted a policy that they would pay for non-emergency out-of-plan claims and send a letter to the member informing them to use the system properly in the future. This "good member relations" policy was not effective at reducing improper use of the system. When Kaiser adopted a policy of denying such claims, their volume dropped by about 60%.

Health Central, in contrast to Fallon and Kaiser, took a cautious approach to marketing their Demonstration. According to plan management, Health Central's sense of caution emanated from the early financial problems experienced by Fallon and Marshfield, and to a lesser degree, Kaiser, as well as within its own commercial group. Health Central's marketing efforts focused on individual selling at senior complexes, and used only limited media advertising. In the first year of the Demonstration, Health Central enrolled less than 500 members. However, Health Central had learned valuable lessons from prior experiences with its commercial population and from the Medicare experiences of Fallon, Marshfield, and Kaiser. The plan had its utilization controls in place prior to implementation of the Demonstration and did an effective job of member orientation and education.

Marketing and promotional strategies which have had varying degrees of success in different settings include: presentations to senior citizen groups and at senior residential complexes, open houses especially for seniors, newspaper ads with coupons to clip and send in for more information, a telephone hotline, endorsements, letters from

employers where group coverage includes retirees, radio advertisements and sponsorships, billboards, and financial incentives, such as the first months of membership at no cost. Kaiser's experience is that TV is the most effective form of media advertising when spotted carefully to attract the highest relative senior audience. Kaiser staff recommend that in marketing contacts with Medicare beneficiaries, answers to questions should be brief and to the point. Marketing representatives should not over-explain, and answers should be limited to 20 seconds or less in length.

In the development of marketing material, simplicity seems to be the key. In their marketing brochures, some plans believe it is more effective to use pictures of young as well as old people. It is generally effective to include a benefits comparison between the HMO's benefit package and standard Medicare coverage. Marketing literature may emphasize that, in contrast to the fee-for-service sector, the HMO will not require completion of claim forms, there are no payment limitations, and more services are covered. Many plans include sample questions and answers relative to their Medicare program. Sample marketing brochures for selected HMO Demonstrations are contained in Appendix E.

All marketing materials, including brochures, media copy and scripts, member handbooks, applications, and any other materials distributed in public, must be approved by a HCFA contract officer from the regional office. The contract officer will seek to ensure that there is full and fair disclosure of all aspects of the Medicare program so that the beneficiary can make an informed decision. Such items as the "lock-in," eligibility requirements, and financial obligations should be stated in a clear and understandable manner.

With respect to enrollment applications, simplicity is again important. Sample enrollment applications from Health Central and Share Health Plan are contained in Appendix F. Several Demonstration HMOs recommend that a blank copy of the Medicare card be placed on the enrollment application with instructions to fill in the blanks exactly as

they appear on the card. This appears to reduce the error rate on the applications, which can disrupt the enrollment process.

Staffing requirements for marketing the Medicare programs at the HMO Demonstration sites varied. Most plans dedicated at least one full-time person to Medicare marketing and servicing. Medicare marketing representatives should have a high degree of patience. While certain plans advocate hiring senior citizens to be Medicare marketing representatives, others, the Fallon Community Health Plan in particular, feel that younger marketing representatives are more likely to have the energy and patience levels that they view as requirements for this job. The size of the marketing staff will of course, be a function of the number of beneficiaries the Plan decides to enroll.

There does not appear to be a definite pattern of higher or lower marketing costs for Medicare when compared to a commercial population. The fact that Medicare marketing is time consuming and focuses on individuals may be offset by the fact, observed in the Demonstrations, that a higher percentage of Medicare beneficiaries who attend presentations or request marketing information decide to join the Plan. A preliminary analysis of Medicare marketing costs indicated costs of $2.90 per member per month at Fallon and $1.15 per member per month at Kaiser. These figures are not inconsistent with marketing costs for commercial groups at many HMOs.

C. Health Care Delivery

Providing care to the aged and disabled populations creates new medical service delivery demands on an HMO. The most obvious demands placed on the delivery system emanate from the greater number of encounters required by the average Medicare beneficiary, an increase in the intensity (e.g., time per unit of service) of professional and ancillary services, and the resultant need for more staff. Because Medicare beneficiaries require a greater volume and intensity of services, the task of controlling utilization of those services becomes much more acute (i.e., there is inherently greater risk in serving a Medicare

population on a prepaid basis than an average population from commercial groups).

This review of the potential impact of a Medicare risk program upon the health care delivery system is divided into the following sub-sections:

- Utilization Control
- Beneficiary Orientation
- Service Availability
- Quality Assurance

1. Utilization Control

The importance of utilization controls to a Medicare risk program cannot be over-emphasized. The Project Director for the Medicare Demonstration at Fallon Community Health Plan states that for an HMO establishing a Medicare risk program, "cracks in the delivery system become gaping holes." Inpatient hospital expenses represent the largest single component of expenses which will be incurred. Control of hospital utilization is the most important aspect of utilization control.

The experience of Fallon and Marshfield Demonstrations highlights this point. These plans experienced higher than expected utilization during the first twelve to eighteen months of their programs. It was only after the Plans discovered their untoward hospital utilization experience that new, aggressive efforts to control utilization were implemented. Fallon's efforts have resulted in a 27.5% reduction in hospital utilization over the period from fiscal year 1980 through fiscal year 1982. Marshfield, on the other hand, showed a 12% reduction in hospital utilization from fiscal year 1981 to fiscal year 1982. Both plans developed some excellent techniques for controlling hospital utilization which, if implemented prior to serving Medicare beneficiaries on a risk basis, potentially can enhance the financial performance of the program.

In 1981, Fallon formed three groups in order to control hospital utilization. These are:

- Case Conference Committee
- Short-Stay Committee
- Pre-Admission Review

The Case Conference Committee is perhaps the most significant organizational change that took place at FCHP after the Medicare Demonstration began. The Committee, chaired by a Fallon Clinic physician, consists of the President of the Fallon Clinic, six other Clinic physicians, FCHP's Medical Care Coordinators, Executive Director, and the Medicare Project Director. The Committee meets once a week to review all patients who have been hospitalized for six or more days, and conducts re-reviews of all patients who have been in the hospital for twelve or more days.

A utilization form is completed for each patient who is reviewed. Each case is presented to the Committee by one of the Medical Care Coordinators. The form contains a brief history of the patient, the coordinator's remarks regarding the patient's medical care management, and an evaluation of the patient's potential for discharge. Sample forms from actual cases presented before the Committee appear in Appendix G.

After each case is presented, the Committee discusses opportunities to orchestrate care in a more cost-effective manner. The primary vehicle used by the Committee is transfer to Providence House, a skilled nursing facility adjacent to St. Vincent's Hospital, where approximately 95% of all inpatient hospital services are provided to FCHP members. An example of a case presented before the Committee involved a patient who was ready for discharge to a SNF, but the patient's family wanted the patient admitted to a facility where there were no beds available. Since there was a bed (that FCHP was paying for under contract) available at Providence House, the Committee felt that the Plan should not continue paying for hospitalization if the

patient refused transfer to Providence House. It was apparent, based on this and other cases presented, that the Case Conference Committee was effective at reducing hospital stays when appropriate alternatives to continued stay were available.

Plan management attribute credit for improvement in utilization rates to the success of this Committee. Committee participation has also been a valuable education tool for the Plan. Physicians serve on the Case Conference Committee on a rotating basis. Every three months, three new physicians are appointed to the Committee for a six month period. The Chairman indicated that as of April 1983, about 50% of the Fallon Clinic physicians had served on the Committee. The success of this Committee is apparent. Since 1980, the first year of the Demonstration, when hospital utilization was 2650 days/1000, the rate has declined by 27.5% through 1982, to a rate of around 1921 days/1000.

The activities of the Medical Care Coordinators supplement the activities of the Case Conference Committee and include ongoing utilization review. All admissions to the hospital are reviewed daily. After an approved admission to the hospital, inpatients are reviewed for continued stay on an every other day basis. The Medical Care Coordinators communicate regularly with the attending physicians and with the Medical Director.

Two other utilization review functions taking place at Fallon are the Short Stay Committee and pre-admission review conducted by FCHP Medical Director. The Short Stay Committee was initially formed to do reviews of short term hospitalized patients. However, the Committee found that there was not much room to reduce utilization of these patients. Now the committee is doing initial reviews, which involve a review of hospital admissions for their appropriateness and for completion of all pre-admission testing. The Committee is also considering doing profile review in the future, which includes diagnosis-specific audits of appropriateness of care and length of stay in the hospital. The pre-admission review function involves prior review of all elective

admissions to the hospital. Plan management views these two functions as worthwhile adjuncts to the work of the Case Conference Committee, which continues to play the pivotal role in FCHP's efforts at controlling utilization.

In a situation not unlike FCHP's, the Greater Marshfield Community Health Plan (GMCHP) discovered, after a year into the operation of its Demonstration, its utilization of inpatient hospital services was exceeding budgeted amounts, creating financial problems for the Plan and the Marshfield Clinic. The corrective action taken by the Plan included the following:

- Reporting of all hospital admissions. On a daily basis, the Plan's Medical Director and Associate Medical Director began receiving a list of all GMCHP patients (Medicare and non-Medicare) that were admitted to the hospital. The lists contained the patient's name, admitting physician, and admitting diagnosis. The Medical Director or his Associate reviewed the list for appropriateness of admission.

- Concurrent review by staff nurse. In accordance with PSRO standards, a nurse reviewed daily all hospitalized GMCHP enrollees. Unjustified stays were reported to the Medical Director and dealt with appropriately.

- Greater use of SNF beds. GMCHP began an intensive effort to educate its physicians about substituting SNF days for hospital days wherever possible. This effort included developing a protocol for use of skilled nursing facilities, reporting "days lost" in a hospital while waiting for nursing home care, and better discharge planning.

- Development of a home health program. Nursing and support personnel were hired by the plan to provide services to patients in the home. Since the program was controlled and operated by the Plan, the physicians were more inclined to use the Plan's home health service in place of higher cost institutional care.

- Same day and ambulatory surgery. GMCHP made a concerted effort to educate their physicians about performing surgery on a outpatient basis wherever possible, or have the patient come in for surgery in the morning, and be admitted to the hospital after surgery.

- Use of hospice care. With inpatient and home hospice programs being developed across the country, Marshfield staff began to discuss alternative ways to care for terminal patients who were receiving only palliative treatment. It was anticipated that a hospice program being developed by the local hospital in Marshfield would be a less expensive alternative form of treatment for the terminally ill.

This summarizes the major programs that were implemented or are under development at GMCHP in order to reduce inpatient hospital use. These programs applied both to the general GMCHP program and the Medicare Demonstration Program.

At the other HMO Demonstrations, similar types of utilization controls were put into place. One new, and particularly innovative approach which was developed by Kaiser-Portland, is known as "Pre-Hospitalization Discharge Planning." This program was implemented at Kaiser on an experimental basis for total hip replacement patients, beginning in March 1981. By the end of the second year of the experiment, a noticeable effect upon length of stay for these patients was observed, as compared with a control group of total hip patients who had not been subjected to the pre-hospitalization procedure.

The procedure involves having the patient and his/her family visit and choose a skilled nursing facility prior to the hospital admission. Psychologists, according to the Kaiser study, "have theorized and in some instances substantiated their theories that patients who have control over their own destiny (e.g., post-hospital placements), and who are aware of expected outcome of surgery, reported less pain and might recover faster."[10] From an administrative point of view, this procedure allows for practical discharge planning."[11] The social worker can negotiate to have a bed held at a SNF, which the patient has chosen, if a discharge date can be predicted. Further, the SNF is able to do a

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10 Quotation from Kaiser-Portland internally prepared document, contained in Appendix H.

11 Ibid.

pre-operative assessment of the patient so that they may be able to set more realistic goals for the patient, rather than meeting the patient for the first time during the post-operative recovery phase. A complete description of the procedure and the study can be found in Appendix H to this report. Kaiser staff had hoped, subject to budgetary constraints, to implement similar programs for such procedures as mastectomies, colostomies, amputations and radical neck surgeries.

2. Beneficiary Orientation

Proper education of the Medicare beneficiary is another important part of the utilization control effort. A significant amount of orientation to the medical delivery system takes place during marketing and enrollment activities. A member's initial contacts with the health delivery system can serve as important reinforcement.

One technique that has reportedly worked very well for Health Central is the Intake Interview, conducted by the "Medicare Plus" Coordinator on an individual basis with all new enrollees. A copy of the Intake Interview form is attached as Appendix I. The concept was developed by Health Central Staff who were concerned that many Medicare beneficiaries lacked adequate information about Health Central upon their enrollment. The Plan also lacked adequate medical and social information about the enrollee. Thus, the intake interview evolved.

The interview questionnaire, which includes a medical and social history, is administered by a "Medicare Plus" staff person. The interviewer orients the new member to Health Central's delivery system, helps him/her to select a primary physician, and makes the first appointment for the new member to see that physician. Also, the patient's old medical records are requested. All this usually takes place prior to the member's effective date. The completed intake interview, plus previous medical records, are put into a new medical record which is prepared and sent to the physician prior to the new member's first appointment. Health Central staff feel that the Intake Interview

has been an excellent technique to improve patient care and to resolve some of the early medical management problems that were experienced.

Another approach to orientation to the delivery system which was used initially by Kaiser-Portland is a "getting to know you visit" between the physician and new enrollees. This was a 15 minute, scheduled visit strictly for orientation purposes. Kaiser's Medical Director reported that difficulties were experienced with this approach due to the lack of medical purpose for this visit. Physicians may be uncomfortable in a purely "orientation" role. After a period of time, Kaiser decided that this function was better suited for an administrative person. Any orientation required from a medical perspective (e.g., use of primary care physician, need for referrals) could be accomplished in general conversations at an initial physical exam or other routine office visit to the Plan.

3. Service Availability

An HMO that initiates a Medicare risk contract must anticipate the demands that such a program will place upon the delivery system. There will be a need to adjust both the number and type of staff that are available to serve the Medicare population.

All of the HMO Demonstrations reported some anxieties from their medical staff over the work load implications of the entry of many new Medicare patients. The degree to which a plan should make a volume adjustment in its staffing depends upon many factors: expected Medicare enrollment; use of physician extenders and ancillary professional personnel; and waiting times for appointments, for example. It is difficult to suggest a general formula for adjusting a Plan's staffing needs to accommodate the Medicare Program. Each plan should anticipate its staffing needs, dependent upon local needs and constraints.

In addition to increasing staff, Medicare contractors may want to add new types of practitioners to reflect the needs of a geriatric popu-

lation. At Kaiser, the services of a geriatrician, podiatrist, and social worker were added to the staff during the course of the Demonstration. An endocrinologist, rheumatologist, and nutritionist were added to the staff of the Fallon Clinic largely to serve Medicare beneficiaries.

The advent of the Medicare Demonstrations also gave some of the Plans greater leverage and/or purchasing power in order to bring more services in-house. A Plan may now find it economically feasible to hire full-time staff where previously services were provided under contract. Alternatively, a Medicare risk program can assist a plan in securing more favorable arrangements for services provided under contract.

One interesting example of this, employed by FCHP, has been its approach to distribution of durable medical equipment (DME). Prior to the Senior Plan, there was relatively little use of DME. FCHP used a vendor for equipment rental and set-up, and this relationship was maintained early into the Demonstration. Due to the increased volume of DME utilization from the Senior Plan population, FCHP decided it would be more economical to purchase most of the needed equipment and handle distribution through its pharmacy. Due to the volume of DME purchases by the Plan, FCHP has been able to get more favorable bids on the purchase of equipment. When necessary, the Plan continues to use the same vendor for delivery of equipment and for set up of large beds. In all other cases, the equipment is distributed by FCHP and the patient returns it to the pharmacy when it is no longer needed. FCHP's Medical Care Coordinators also review the necessity for continued use of DME.

Several of the Plans took special measures to accommodate the urgent care needs of the Medicare population, through the blocking out time slots in physician schedules (e.g., Kaiser) and extending of hours at urgent access facilities (e.g., Fallon). Fallon encourages use of the urgent care facility by Senior Plan members because Plan staff feel that a visit to an emergency room by an elderly patient carries a greater likelihood of hospital admission.

Plans developing Medicare risk program may want to consider new approaches to the provision and financing of skilled nursing facility services, home health, and hospice care. A Plan that has not previously served Medicare beneficiaries may have had little need to provide these types of services, and therefore paid little attention to contracting for such services. Each of these services represents a potential lower cost alternative to inpatient hospital care and as such, should be integrated into patient care management strategies.

One strategy for integrating skilled nursing care into hospital discharge planning is to lease beds in a skilled nursing facility. This strategy was adopted successfully at Fallon, and was in process at Health Central. The availability of leased SNF beds played an integral role in the successful utilization control efforts of Fallon's Case Conference Committee. Initially, Fallon paid the same rate whether or not the bed was occupied, and later negotiated a reduced rate (to cover fixed costs only) for unoccupied leased beds.

With respect to home health services, both Marshfield and Health Central hired staff and developed their own in-house programs. This gave the Plan greater control over the program, and gave the medical staff more confidence in the reliability of their respective programs. Fallon contracted with a home health agency to provide these services on a fixed price basis.

Finally, hospice care is not a service found to be in widespread use among the HMO Demonstrations, but was under consideration by Marshfield. Lubitz and Prihoda report that in 1976, 5.2% of the Medicare beneficiaries were in their last year of life and accounted for 28.2% of Medicare program expenditures.[12] While Medicare Patients requiring Hospice Care may eventually represent a status which excludes them

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12 James Lubitz and Ronald Prihoda, "Use and Costs of Medicare Services in the Last Years of Life", draft report prepared for Office of Research and Office of Data Management and Statistics, Health Care Financing Administration, June 29, 1982, p.6.

from coverage under an HMO arrangement, home care to terminally ill patients represent another option for HMOs to orchestrate medical care in a more cost-effective manner.

One other new service added by Marshfield is the Elderly Evaluation Center, designed to coordinate the Plan's approach to addressing medical and social problems of elderly patients. To the extent possible, the Center uses community resources and health education activities which are available to assist patients in maintaining their autonomy. Though this program was only in the initial stages of development, Marshfield staff were optimistic about its cost savings potential.

MedCenter innovatively used clinical personnel as well as marketing staff to make presentations to Medicare beneficiaries. A senior Health Services Department was established at the St. Louis Park Medical Center for this purpose and it provided educational programs on various health issues.

4. Quality Assurance

It is assumed that a new Medicare risk contractor will have a quality assurance program in place and that quality assurance issues related to Medicare beneficiaries will be handled consistent with this program. However, due to the special needs of Medicare beneficiaries and the higher risk associated with developing a Medicare risk contract, a Plan may wish to set up some special mechanisms to identify issues, facilitate decision-making, and resolve problems specific to this program.

For example, Kaiser-Portland established "steering" and "operations" committees to prepare for the Demonstration. The operations committee evolved in a "Geriatrics Task Force" to discuss current issues and program improvements relative to Medicare. This group supports

the overall quality assurance function at Kaiser, with emphasis on the Medicare program.

The Fallon Community Health Plan established a Senior Plan Advisory Committee consisting of several Senior Plan members. This group serves to identify health delivery and other issues related to the Medicare Program. The group not only acts in an important consultative role to Health Plan staff members concerned with delivery system issues, but also serves an important marketing function for Fallon, by acting as a focus group to "test" marketing materials and promotional ideas.

D. Contract Administration

In planning for a Medicare risk program, an HMO should recognize that the Medicare program is very specialized in its approach to financial planning, marketing, health care delivery, and administration. From the point of view of the Demonstration HMOs and the HCFA evaluators, the degree to which the HMO Demonstrations dedicated staff and other resources to development and ongoing operations of the Medicare contract seemed to correlate with the success of the venture. In this section, the special administrative needs of the Medicare Program are reviewed.

1. Accretion/Deletion Processing

Much of the administrative detail related to Medicare risk contracting centers around enrollment and disenrollment of Medicare members, and claims processing/payment procedures. These functions are carried out in conjunction with the Systems Branch of Group Health Plan Operations at HCFA.

The primary data processed by the Systems Branch are enrollment and disenrollment information from each contracting HMO. The enrollment of a Medicare beneficiary under an HMO Medicare contract is known

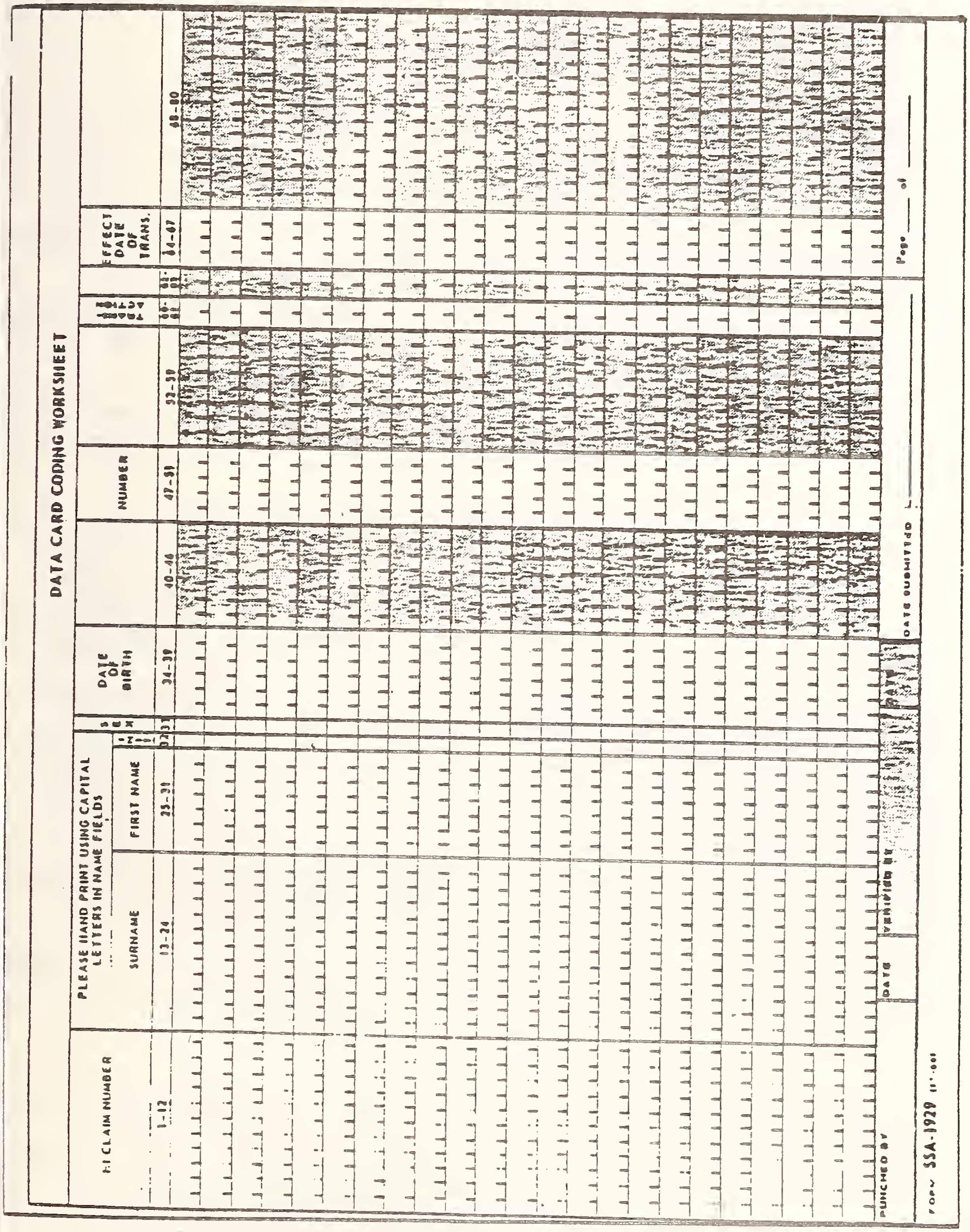
as an "accretion." The process of disenrolling a Medicare member is known as a "deletion." Chapters 3 and 4 of the HMO Interim Operating Instructions describe accretion/deletion processing for Medicare contractors. HMO staff should be well versed in these procedures.

All accretions and deletions must be reported to HCFA by the 15th of a given month in order for the member to begin receiving services on the first of the following month. This means that, if all the information is transmitted accurately, there is a two to six week wait for a Medicare beneficiary to become eligible to receive benefits. Many HMOs impose a 10th of the month deadline to allow time for processing and to ensure next month eligibility.

Enrollment and disenrollment information can be transmitted in various ways. The first option is to send a magnetic tape. This option is, of course, only cost effective for larger plans. GHPO staff prefer use of the tape option if monthly accretion/deletion volume exceeds 500. Other plans send punched computer cards which can be entered directly into the computer. The final option is to submit completed HCFA Form 1929, (Exhibit IV-5) which contains all the necessary transaction information. Plans that do not submit magnetic tapes are encouraged to submit punched cards, but any of the three options is acceptable.

The most important piece of information is the beneficiary's Health Insurance Claim (HIC) number, which should be copied from the Medicare card. GHPO staff indicate that there is approximately a 10% error rate in HIC numbers which are reported by plans. This is a significant problem that is most easily dealt with through more careful data collection by the plan. HCFA will not make retroactive adjustments to an individual's enrollment status if the original error was on the part of the plan. Adjustments will, however, be made in the event errors

Exhibit IV-5



DATA CARD CODING WORKSHEET

HI CLAIM NUMBER	PLEASE HAND PRINT USING CAPITAL LETTERS IN NAME FIELDS			SEX	DATE OF BIRTH		NUMBER				EFFECT DATE OF TRANS.	
	SURNAME	FIRST NAME										
1-12	13-24	25-31	32	33	34-39	40-46	47-51	52-59	60-61	62-63	64-67	68-80

PUNCHED BY | DATE | VERIFIED BY | DATE | DATE SUBMITTED | Page ___ of ___

FORM SSA-1929

are made by GHPO. Regardless of who is at fault, discrepancies that lead to delays in processing often confuse the Medicare beneficiary (i.e., from whom should I receive my medical care?) and result in distrust of the HMO and Medicare. Therefore, every effort should be made to ensure the accuracy of reported information.

The schedule for processing of accretions and deletions is as follows:

- The accretion/deletion listing is sent by the HMO to HCFA (GHPO) by the 15th of the month.
- GHPO sends all data from all participating plans to the Social Security Administration for processing by the 25th of the month.
- Social Security processing of changes to each beneficiary's Health Insurance Master File is completed by about the 5th of the following month.
- "Reply Listings" are sent to participating plans by the 10th of the following month (see Exhibit IV-6.)

Thus, there is risk involved in assuring, for example, that a beneficiary can be enrolled two weeks after the 15th of the month submission, since the HMO will not receive the reply listing from HCFA until about 10 days after the promised effective date. If it turns out that the member is not eligible for Medicare benefits, or the accretion is rejected due to an error in reporting, the plan may have begun to provide services for which it is not being compensated. If an enrollee is rejected by HCFA because of inaccurate information, and the enrollee is in fact Medicare-covered, then the HMO can bill the appropriate Part B carrier for any services rendered between the expected eligiblity date and the notice of error. If the error is corrected, the HMO can be fairly certain of eligibility for the next month.

If an HMO wishes to be perfectly safe, a six-week lead time for official enrollment is recommended by some HCFA staff. This provides for one cycle of response listings to be returned in accordance with the above schedule, so that the HMO can determine who has been accepted,

Last Name, First Name	H.I. Number	15	6	7	8	90	1	2	13	14	15	6	17	REMARKS
			2060918		103901		116	J	1282	1282	1282			
			1022613		103901		116	N	1282	1282	1282			
			2020293		103901		2752				0682		FINAL REJECT	CLAIM NUMBER WAS NOT FOUND IN OUR FILE.
			1021606		103901		116	N	1282	1282	1282			
			1122617		103901		116	N	1282	1282	1282			
		E	2122917		103901		116	N	1282	1282	1282			
			2100316		103901		116	N	1282	1282	1282			
			1040698		103901		1752	N			1082		1182X	
		M	2032011		103901		116	N	1282	1282	1282			
			1051316		103901		116	N	1282	1282	1282			
			1082118		103901		116	N	1282	1282	1282			
		M2			103901		43	N					1182	BENEFICIARY DECEASED.
		P	2110617		103901		116	N	1282	1282	1282			
		R	2010608		103901		266			0281	1282		103905	CURRENTLY ENROLLED IN PLAN 103905
		E	2110817		103901		116	N	1282	1282	1282			
			1090814		103901		116	N	1282	1282	1282			
			1061018		103901		116	N	1282	1282X	1082			
			2042816		103901		116	N	1282	1282	1282			
		S	2033017		103901		3161				1282		00	UNDER INVESTIGATION-PLEASE DO NOT RESUBMIT.
		C	1060398		103901		118	N	1282	1282	1282			
			2061716		103901		116	N	1282	1282	1282			
			1111616		103901		116	N	1282	1282	1282			
			2042510		103901		1752	N			1082		1182X	
		L	2		103901		43	N					1282	BENEFICIARY DECEASED.
			1051217		103901		1751	N			0882		1182X	
			1120112		103901		256	N	1182	1182	0882			DUPLICATE TRANSACTION.
		R	1102722		103901		116	J	1282	1282	1282			
			2111417		103901		116	N	1282	1282	1282			
		A	1071899		103901		3161				1282		00	UNDER INVESTIGATION-PLEASE DO NOT RESUBMIT.
		F	1071316		103901		116	J	1282	1282	1282			
		C	1		103901		43	N					1182	BENEFICIARY DECEASED.
		YE	1		103901		46	J					1282	ENTITLEMENT TERMINATED.
		YE	1		103901	044		J					1282	PART A TERMINATED.
		M	2122616		103901		116	N	1282	1282	1282			
		D	2072694		103901		1752	N			1082		1182X	
		YM	2081317		103901		41	N					1850950580	NOTE CORRECT CLAIM NUMBER.
		MI	1123117		103901		116	N	1282	1282	1282			
		G	2111610		103901		256	N	1182	1182	0882			DUPLICATE TRANSACTION.
		D	1112317		103901		116	N	1282	1282	1282			
		W	1033096		103901		116	N	1282	1282	1282			
		M	2111239		103901		116	N	1282	1282	1282			
		S	2020816		103901		116	J	1282	1282	1282			
		C	2041014		103901		1752	N			1082		1182X	
			2101216		103901		116	N	1282	1282	1282			
		F	1121826		103901		116	J	1282	1282	1282			
		L	1050314		103901		3152				1082		00	UNDER INVESTIGATION-PLEASE DO NOT RESUBMIT.
			1012706		103901		116	N	1282	1282	1282			
		E	1030306		103901		116	N	1282	1282	1282			
		N	2		103901		43	N					1182	BENEFICIARY DECEASED.
			1042630		103901		1752	J			1082		1182X	

for whom additional information is required, and who has been rejected. Then, the HMO can follow up with appropriate orientation information to accepted individuals, supplementary information requests to those who have not yet been accepted by HCFA, and notifications to those rejected, all without having incurred any risk for services rendered.

Many HMOs, however, decide to take the early enrollment risk outlined above, for reasons of marketing advantage (too long a lead time can be detrimental in enrollment efforts), more effective coordination with expiration dates of existing "wrap around" policies (if a date is missed, an individual may decide to keep his old policy), and because good initial application monitoring procedures can very effectively minimize the risk of inaccurate or improper information, and reduce the error rate to a point well below the 10% average quoted by GHPO staff.

A crucial element in the minimizing of this risk, besides initial application control, is immediate reconciliation between the accretion/deletion listing submitted by the HMO and the reply listing received from GHPO.

In addition to the accretion listing submitted on a monthly basis to HCFA, the plan must submit information on the same forms about institutional and welfare status of their enrollees. In order to calculate the rate of payment, each member must be assigned to a rate cell in the AAPCC ratebook. The GHPO computer system will automatically assign beneficiaries to the proper age and sex cell, and will assume that the beneficiary is non-institutionalized, non-welfare unless otherwise instructed. Each plan must report data on institutional and welfare status as follows:

- A member is intitutionalized if he/she has been in an institution other than a short stay hospital for 30 or more days. All institutionalized members must be reported <u>each</u> month in order to be paid at the higher rate.

- A member is on welfare if he/she is eligible for Medicaid[15] and the state has exercised its "buy-in" option with Medicare. Once a plan reports that a member is on welfare, the computer assumes that the person remains on welfare status until instructed otherwise.

There have, on occasion in the Demonstrations, been some problems with respect to processing disenrollment. If a plan tells a member that he/she is disenrolled by the first of a given month but the transaction is rejected by the computer (usually because of an incorrect number), the problem can take two months to reconcile if the reply listing is received late. This type of problem can, however, be corrected with a retroactive transaction. At Fallon, a person would occasionally stop paying their bills in order to disenroll, resulting in confusion on the part of the Plan regarding eligibility status. Fallon later issued a policy that all disenrollments were required in written form. It is recommended, for the protection of the plan, that disenrollments be in written form and, in order to minimize any confusion over eligibility status, that careful attention be paid to the transaction data that are sent to HCFA.

2. Claims Processing/Payment Procedures

An HMO receives a prospective payment from HCFA equal to 95% of HCFA's expected per capita costs. HCFA's costs are determined on the basis of law and regulation relative to "allowable costs" under the Social Security Act, which is often significantly less than the provider's charges for its services. An organization that pays charges, but receives its payment from HCFA based on 95% of allowable costs, may be placed in a considerable bind. In order to deal with this situation, contracting organizations under TEFRA are given the option of paying

15 For those eligible for Medicare and Medicaid, a State may "buy-in" to the Medicare program by paying the Part B premium on behalf of its dual eligible.

at the Medicare allowable cost level[16] for inpatient hospitalization only by using the Medicare intermediary to pay these bills.

HMOs must elect one of the following three options for paying of provider claims. These are:

- Option A - HCFA processes all bills and the HMO does not process any.
- Option B - HMO processes bills for "directly provided" services and HCFA pays all other bills. "Directly provided" services have been interpreted to include services provided under contractual arrangements, such as hospital services.
- Option C - HMO processes all bills and HCFA does not process any.

Options B and C do exclude payment for outpatient treatment of chronic renal disease, which is paid for by HCFA in both cases.

It is not likely that an organization with a Medicare risk contract would consider Option A because the Plan would not get an upfront, cash payment, which is the essence of prepaid contracting. Options B and C, however, are both viable alternatives, depending upon local circumstances.

Under Option B, an HMO would pay all its own claims except for hospital bills from institutions with which the HMO does not contract. An HMO with no hospital contracts, which presumably is paying hospital charges, may choose Option B in order to pay at the Medicare "allowable cost" rate, instead of charges. Option B has the advantage that it may be used selectively. A Plan that can negotiate one or two hospital contracts may directly pay those hospital providers at negotiated rates,

16 As of October 1, 1983, HCFA began to phase in a diagnostic-related-group (DRG) method of payment to hospitals under the Medicare program. With only few exceptions, hospitals will receive a cost-per-case payment based upon diagnosis, regardless of how long the patient stays in the hospital.

and HCFA would pay all other hospitals at "allowable cost" rates. Even if an HMO has contracts with all its local hospitals, it may exercise Option B in order to have HCFA pay its out of area claims at the "allowable cost" rate.

The major disadvantage of Option B is that a portion of the HMO's expected prospective payment is withheld by HCFA in order to compensate for the claims to be paid by the intermediary. A withhold amount must be agreed upon between the Plan and HCFA, and this amount will be adjusted up or down if actual experience of claims paid by HCFA differs from what was expected. At the end of the year, there will be a reconciliation between the amount withheld by HCFA and actual claims paid. Furthermore, the reconciliation process will not be concluded until several months after the close of the fiscal year. Therefore, the benefits of Option B should be weighed against the disadvantages of reduced cash flow and the need for reconciliation of claims paid by HCFA.

Under payment Option C, the HMO pays all claims. The legislation which instituted DRG propective payment of hospital exempted risk-basis HMOs from the cost-per-case payment requirement. Therefore, these HMOs are free to negotiate rates based upon a fixed payment per diem, a service-based per diem, a leased-bed arrangement, capitation payment, or any other arrangement. Under Option C, there is no withhold from the Plan's prospective payment. Hospital bills under Option C are paid on whatever basis can be negotiated by the HMO.

Option C is likely to be the most attractive alternative if a Plan has one or more hospital contracts in place to cover most of its hospital utilization. However, in the absence of those contracts and if faced with paying hospital charges, Option B may be preferable. HMOs may want to use Option B as its leverage for negotiating a favorable contract from its hospitals, particularly since many hospitals may prefer payment arrangements for Medicare patients other than that based upon the DRG system.

It is important for Medicare risk contractors to communicate with local hospitals about the nature of this contract and proper payment procedures associated with it. Exhibit IV-7 shows a letter sent out to hospitals prior to instituting the HMO Demonstration at Kaiser-Portland, which exercised payment Option C during the Demonstration.

In order to assist hospitals in taking the proper billing steps, the HMO should provide effective forms of identification for the HMO Medicare member, which minimizes the potential for misuse of the Medicare card. The Plan may provide a identification cardholder for the members HMO card and Medicare card, place a sticker on the Medicare card which identifies the beneficiary as a Plan member, or encase the Medicare card in a plastic overlay which provides similar identification (see Marketing section). This will advise the hospital that they should go directly to the HMO for payment (in the case of Option C or if there is a contract) and they should provide service only if the patient has been referred or it is an emergency.

The Medicare intermediaries/carriers will also be given instructions about Medicare risk contracting. A letter sent to Medicare Intermediaries/Carriers prior to the Medicare HMO Demonstration Project is shown in Appendix I. If the hospital goes through its normal query process through the Medicare intermediary, the hospital will be notified a few days later to bill the Plan for services (unless the intermediary is responsible for payment under Option B). This, however, may be several days after an admission. If it was an inappropriate admission, the HMO will not pay the claim and neither will HCFA. Therefore, it is most important that the HMO Medicare member be identified upon presentation at the hospital.

Another administrative requirement for Medicare risk contractors is completion of HCFA Form 1453 for all inpatient hospital and SNF admissions. This form must be sent to HCFA even in the instances where the HMO is paying the bills. The purpose of this "dummy claims" reporting requirement is to allow HCFA to keep track of the beneficiary's use of lifetime reserve days, in the event the beneficiary disenrolls and his/her regular Medicare benefits must be reinstated.

Plans may want to consider having hospital bills sent to the HMO on HCFA Form 1453, which can than be forwarded to HCFA in order to satisfy this requirement.

The final section of this document briefly summarizes the experiences of each of the HMO Demonstrations, and observations of HCFA's evaluators.

V. SUMMARY OF DEMONSTRATION EXPERIENCE

A. Fallon Community Health Plan

The Fallon Community Health Plan (FCHP) is a group practice HMO located in Worcester, Massachusetts. The Plan was founded in 1977 through the joint efforts of the Fallon Clinic and Blue Cross of Massachusetts. Professional medical services are provided to FCHP through the Fallon Clinic, which has one main facility and two satellite facilities. As of January 1983, over 42,000 members were enrolled in FCHP. The Medicare Demonstration Program at Fallon, called Senior Health Plan, became operational in April 1980.

FCHP and the Fallon Clinic experienced early financial difficulty as a result of the Demonstration. Two factors were largely responsible for this: the Plan's approach to rate setting and its approach to marketing. FCHP's objective was to rapidly enroll large numbers of beneficiaries. FCHP's marketing efforts resulted in an enrollment of 5300 Medicare beneficiaries during the first nine months of the Demonstration (April 1980 - December 1980). However, the Plan reported that there was a relatively high error rate in the application process and there was a segment of the new membership that lacked a basic understanding of the Demonstration (e.g., the "lock in").

Fallon had no experience in providing health services to Medicare beneficiaries upon which to base its rates. In the absence of such data, FCHP assumed that the ratio of hospital days used by the population under age 65 to that for the population over 65, as experienced by Kaiser-Permanente of Northern California, would also apply to FCHP. By applying this ratio to FCHP's under 65 hospital utilization rate, a projected number of hospital days was determined for the Medicare Demonstration. This resulted in payments from HCFA to FCHP based upon hospital utilization of 2300 days/1000 Medicare members in a service area (Worcester County) that was experiencing well over 4000 days/1000 Medicare beneficiaries. Fallon's actual hospital utilization experience in the first year was 2650 days/1000 as opposed to the 2300

prediction. Thus, despite good hospital utilization performance in comparison with local fee-for-service history, the negative variance from predicted days was a major reason for FCHP's early financial difficulty.

FCHP responded to this negative performance by implementing organizational and procedural changes in an effort to reduce use of inpatient hospital services and better orient and educate its new members. A Case Conference Committee began meeting weekly to review all inpatient hospital stays of six or more days. Through 1982, according to hospital utilization statistics provided by FCHP, utilization rates have been reduced by 27.5% from the levels realized at the outset of the Demonstration. This Committee apparently served as an effective educational tool for Fallon Clinic physicians on how to "orchestrate" medical care in the direction of more cost-effective forms of treatment, since the beginning of the downward trend in hospital utilization coincided with the formation of the Committee.

With regard to orientation and education, FCHP's marketing efforts have de-emphasized mass marketing and are more focused. New members must now talk to á marketing representative prior to enrollment. To reduce confusion and inappropriate use of the system, members are given FCHP identification card holders with separate plastic sleeves for their Medicare and Plan ID cards. The cardholder contains instructions to the member on proper use of the system, and has billing instructions for providers. In addition, the marketing department has established a Senior Plan Advisory Committee, developed a special Senior Plan newsletter, and solicited feedback from Medicare members in order to increase member satisfaction and retention.

Other organizational changes which took place at FCHP include the following:

- FCHP has made a major effort to control use of referral services, through establishing more provider contracts, placing providers at greater risk, and buying more services in house.

- FCHP established a contract to lease beds from a skilled nursing facility adjacent to its primary hospital in order to ensure the availability of a lower cost alternative to inpatient hospitalization.

- Fallon Clinic staff indicate that the working relationship between the Clinic and FCHP has become a more cooperative one, resulting from a growing interdependence and greater sharing of risk.

- FCHP has made greater use of its urgent access facilities and pre-empted many hospital admissions that would have resulted from a Medicare beneficiary's visit to an emergency room.

- The Plan now has pharmacy and optical services available in its clinics and now distributes durable medical equipment through its pharmacy.

- FCHP has improved its grievance procedure in order to expedite resolution of problems and provide better protection to the Plan in the event of a formal grievance petitition to HCFA.

Overall, the management staff of FCHP believe the organizational impact of the Demonstration upon FCHP has been quite positive. The financial impact of the Medicare Program, after some early problems for the Plan and the Fallon Clinic, was quite good. FCHP's hospital utilization problem was not uncovered until late 1980, after FCHP's ACR for 1981 had already been developed. Therefore, hospital utilization projections were too low for 1981 as well as 1980. Also contributing to FCHP's financial problem in 1981 was a $42 negative variance in its cost per hospital day, according to data reported by the Plan. Increases in hospital charges were passed on to FCHP in the absence of a fixed-price, per diem or other arrangement which transfers financial risk to the hospital.

In 1980, in spite of a large negative variance in hospital utilization, the Plan roughly broke even on the Demonstration for the year. This was because: 1) there was a large positive variance on skilled nursing facility costs due to actual utilization of 200 days/1000 compared with budgeted utilization of 1100 days/1000 and 2) FCHP had an aggregate stop loss arrangement with Blue Cross of Massachusetts which

partially compensated the Plan for greater than expected utilization. In 1981, the Demonstration did lose money because hospital utilization rates and daily costs were higher than expected, and because the Plan was no longer protected from aggregate stop-loss. By 1982 and through 1983, because of improved financial forecasting and the organizational changes reported herein, the Medicare Demonstration produced a positive contribution for FCHP.

It appears that the impact upon the Medicare beneficiaries has been positive as well. Patient satisfaction, as measured by the Plan's internal surveys and by the results of a survey conducted under the HCFA evaluation, has been extremely high. For example, 94.3% of FCHP's Medicare members evaluation reponding to the HCFA survey indicate that they are "very satisfied" with their overall care. At the time of the survey (i.e., October - November 1982), only 2% of the enrollees had cancelled their membership.

In conclusion, FCHP's Medicare Demonstration Program is an excellent case study due to the turnaround that has taken place in the Plan's performance. The Demonstration is now contributing to the financial well being of the Plan, and has been well received by Plan administration, Fallon Clinic physicians, and the Medicare beneficiaries.

B. Greater Marshfield Community Health Plan

The Greater Marshfield Community Health Plan, (GMCHP) is a state certified prepaid program of the Marshfield Clinic, a large multi-specialty group practice in central Wisconsin. The Marshfield Clinic, which is primarily a fee-for-service physician group practice, is the dominant provider of physician services in central Wisconsin. Traditionally, the Clinic has used a cost based approach to rate setting. Clinic physicians paid little attention to cost-effectiveness of medical care rendered, did not monitor hospital utilization, and (beginning in 1979) received incentive payments based upon productivity, defined in terms of the volume of service provided. Many of these attributes counter efforts to control costs found in a typical HMO.

GMCHP was established by the Clinic in 1971. The cost based approach to rate setting, as described above, was continued for the Plan. Since the Marshfield Clinic is the major provider group in the area, little attention was paid to altering utilization patterns or increasing efficiency for the Plan. GMCHP was another mechanism to finance the same level of care normally provided at the Marshfield Clinic.

This approach continued when the Medicare Demonstration Program began at GMCHP in June 1980. The Program was well received in the community, and enrollment increased rapidly. By the end of 1980, enrollment in the Demonstration Program reached 7235 members, representing about 41% of the Medicare beneficiaries living in GMCHP's original service area.

Approximately one year into the Demonstration Program, it became apparent that sufficient revenues were not being generated to meet budgetary requirements established for the program. In the fiscal year ending September 30, 1981, GMCHP lost approximately $1.5 million on the Medicare program despite a HCFA premium of 99% of AAPCC in the first year. Once the magnitude of the problem was realized, corrective action was begun.

Initially, the major effect of the Demonstration was organizational awareness of the negative financial impact of the Medicare Program upon GMCHP and the Marshfield Clinic. Marshfield physicians initially resisted changes to their traditional modes of practice in the interest of efficiency and cost containment. However, as of October 1981, this resistance was beginning to erode. Through monitoring (but not authorizing) hospital admissions and lengths of stay and implementing utilization review programs in a few outpatient departments of the Marshfield Clinic, modest effort to control costs began.

By mid-1982, significant changes in operational procedures appeared. New initiatives to further the effort of cost containment were regularly being discussed among GMCHP physician and administra-

tive staff. A reduction in hospital utilization, the major source of cost overruns, was the most significant change. Hospital utilization in fiscal year 1982 (through June) was down by 12% compared to the same period in the previous fiscal year. Many factors account for this phenomenon, including better utilization review, greater use of skilled nursing and home health care service alternatives, better discharge planning, use of outpatient surgery alternatives, and a financial incentive program tied to reductions in hospital utilization. There were also many improvements in outpatient utilization review at GMCHP.

The Medicare program and GMCHP lost money again in fiscal year 1982 (approximately $540,000) and as a result, their contract was terminated by HCFA. As discussed in the financial management section, GMCHP had a loss sharing arrangement with HCFA in fiscal year 1981. As a result of this arrangement, HCFA payment to GMCHP exceeded 100% of the AAPCC in 1981, leading HCFA to decide to terminate the contract. The Demonstration ended despite GMCHP's desire to continue the program (with a much less generous loss sharing arrangement), the demonstrated reduction in hospital utilization rates and other efficiencies which were induced by the Medicare program, and the perception of Plan management that the program would become financially viable (without participation by HCFA in a loss sharing arrangement) in another year.

There are a set of potentially interrelated factors which may have contributed to the financial problems of the Medicare Demonstration Project at Marshfield. These include the following:

- Marshfield Clinic is a higher cost, tertiary care provider operating a larger, rural area where medical costs (and the AAPCC) are lower.
- Marshfield Clinic is the major provider in the area. Therefore, Clinic costs largely determined the AAPCC, and GMCHP was receiving a percentage (between 95 and 99) of the AAPCC.

- Marshfield Clinic did not accept Medicare assignment prior to the Demonstration. Therefore, Medicare beneficiaries had to pay 20% or more of charges to receive care at the Clinic. Marshfield staff hypothesized that this was a financial barrier to receiving medical care, and that when the Demonstration began, there was a surge in demand for medical care.[18]

- The Medicare Demonstration was announced to local residents six months before it began. It has been hypothesized that Medicare beneficiaries delayed elective procedures until after the Demonstration began, which added to Marshfield's cost problems.[17]

- Marshfield had an open enrollment policy, allowing beneficiaries to join at any time, including when they needed an expensive procedure.

- At the outset of the Demonstration, GMCHP was lacking utilization controls and incentives that promote efficiency and financial stability in an HMO.

The Demonstration program at GMCHP was the impetus for significant control of health care costs, but the impetus may have come too late. GMCHP's Medicare Demonstration is an interesting case study because it was the only Demonstration contract not renewed by HCFA. To the new Medicare risk contractor, the Marshfield experience indicates the variety of problems that may be encountered, and offers evidence of the importance of instituting preventive action to minimize potential negative financial impact.

C. Kaiser Foundation Health Plan (Oregon)

The Kaiser Permanente Medical Care Plan (KPMCP) - Oregon Region, has conducted its Medicare Demonstration Project since August 1980. Kaiser's Demonstration evidences a high level of corporate commitment and a well organized management approach to the project.

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17 Patterns of utilization among enrollees are under study as part of HCFA's evaluation of the HMO Medicare Demonstration and results will be published at a later date.

Organizationally, the most salient feature of Kaiser's project was the intra-organizational planning and control system used to prepare for and implement the program. Kaiser's managerial approach emphasized multi-disciplinary input and responsibility through "steering" and "operations" committees. This group planning and problem solving method provided KPMCP with a sound base for organizing and administering the project, and a means of identifying and resolving emerging issues.

KPMCP staff report that the program was a "financial success", but it is unclear whether or not this means that the Demonstration made money. Kaiser took a unique approach to the Demonstration by offering the following benefit package options:

1. Comprehensive Medicare benefits (standard Part A and B benefits with no limitations, deductibles, or copayments, plus routine physician and preventive services).

2. Comprehensive Medicare benefits plus pharmacy, vision, and hearing benefits.

3. Comprehensive Medicare benefits plus dental.

4. Comprehensive Medicare benefits plus all options 2 and 3.

KPMCP staff calculated a premium which reflected the value of additional benefits in the comprehensive package. However, Kaiser did not charge a premium for its comprehensive package in 1980 and 1981, and charged $5 per month in 1982. While only limited financial data has been provided to HCFA's evaluators, it is their impression that KPMCP incurred a relatively small net loss for the first three years of the Demonstration because they did not charge a premium. KPMCP could have realized an additional $1.8 million in premium revenue, which would have resulted in a surplus for the program. Over this period of time, Kaiser also established a reserve fund of approximately $315,000 which was accrued by HCFA from funds not exceeding 95% of AAPCC. These facts taken together do seem to substantiate that this was a financially viable Demonstration.

The significant programmatic changes which took place at KPMCP have been reported in the text of this report. Kaiser's approach to the Demonstration provides valuable information with respect to effective approaches to marketing, enforcement of the "lock-in", the use of a multi-disciplinary operations committee which evolved into a "Geriatrics Task Force", and development of an innovative "Pre-hospitalization Discharge Planning" Program.

D. Interstudy

The Medicare Demonstration Project in Minneapolis/St. Paul has assumed a different character from the other programs. Interstudy, a health care education and consulting firm, has served as project coordinator and as a source of market information for the four participating HMOs. The participating HMOs are as follows:

a. HMO Minnesota - This plan is an affiliate of BC/BS of Minnesota. HMO Minnesota (HMOM) contracts with BC/BS for management services. HMOM contracts with independent physician groups throughout the metropolitan area for physician services. Over 1,000 physicians at over 60 delivery sites are under contract with HMO Minnesota.

b. MedCenter Health Plan - This plan is associated primarily with St. Louis Park Medical Center, but also contracts with three other smaller physician groups. MedCenter has been in operation since 1972 and began the Demonstration with a commercial program membership in excess of 65,000.

c. Nicollet/Eitel Health Plan - Nicollett/Eitel is a non-profit HMO controlled by the Nicollet Clinic, P.A and Eitel Hospital in Minneapolis. Nicollet Clinic is a multi-specialty group practice founded in 1921. Pre-Demonstration commercial enrollment was approximately 21,000 members.

d. SHARE Health Plan - SHARE is a non-profit HMO which has been operational since 1974. SHARE is the only one of the Demonstration plans in Minneapolis which had a Medicare cost contract prior to the Demonstration. The enrollees from the cost contract were transferred to the Demonstration program.

Each of the HMOs has offered a high and low option benefit package. There are minor variations among the plans with respect to these benefit packages (see Exhibit IV-1). Essentially, the low option pack-

ages provide basic Medicare benefits plus coverage of deductibles and copayments. The high option packages varied among HMOs, adding selected additional services to the basic benefit package. Waivers were granted to permit screening of enrollees by the HMOs, applicable only to enrollment in the high option plan. All Medicare beneficiaries, including those rejected from the high option plan, were permitted to enroll in the low option program during a one month annual open enrollment period.

The role of Interstudy in the Demonstration was to serve as a "coordinator" between HCFA, the participating HMOs, and the Medicare beneficiaries. One of Interstudy's original roles was to develop the "Wiser Buyer" program, which was a unique attempt to create a structured, competitive environment under which objective information was presented to prospective Medicare enrollees relative to their multiple choice of health coverage. The program, which was conducted during the first year of the Demonstration, included educational meetings held in various senior and community centers, churches, and other public gatherings. Interstudy was also responsible for a "consumer hotline", a primary source of information for Medicare beneficiaires.

After the first year, Interstudy did no further marketing activities for the Demonstration. Each of the HMOs conducted their own marketing programs using many of the techniques described in the marketing management section. Interstudy's role was reduced to one of project coordination and reporting to HCFA.

The results of the Demonstration in Minneapolis were mixed for the participating HMOs. At the end of 1982, SHARE had enrolled over 9,000 Medicare beneficiaries, while MedCenter had enrolled approximately 2,000 members, and HMO Minnesota and Nicollet-Eitel had fewer than 1,000 each. By September 1983, enrollment had increased to 19,431 at SHARE, 4191 at MedCenter, 2,453 at HMOM, and 1,278 at Nicollet-Eitel.

SHARE has had the most success to date of the Minneapolis HMOs, both financially and operationally. SHARE reported some early confusion on the part of patients related to proper use of the delivery system and to notification of hospitals by the intermediary (i.e., Blue Cross) to bill SHARE directly for admissions. The other plans also reported this problem. Member education improved the first problem, and SHARE staff reported satisfaction with the ability of GHPO to deal with the latter problem. SHARE aggressively marketed their program as an adjunct to the activities of the "Wiser Buyer" promotion. Operationally, the Medicare program became SHARE's central focus, with top management involved and committed to its success. SHARE's management report that the Plan's growth over the last three years is largely due to the marketing and financial success of the Medicare program.

At HMOM, enrollment proceeded very slowly. In part, this was because HMOM initially used very stringent underwriting criteria and rejected 90% of the applicants to their high option program. After a year, the rejection rate dropped to 60%, which was still higher than the other plans. Furthermore, HMOM places its contracting groups at full risk for inpatient and outpatient care, and many physicians initially felt this was an unacceptable level of risk. As a result, the program did not receive the support that was originally anticipated for it, and the program remained only a small part of HMOM's business through the middle of 1983. In recent months, HMOM has made a corporate decision to market the program more aggressively, and it appears to be resulting in higher levels of enrollment.

MedCenter, in spite of its relatively low enrollment, responded in innovative ways to the Demonstration. MedCenter used clinical personnel in addition to marketing staff at its presentations to Medicare beneficiaries. Presentations included an educational program presented by clinical staff. A Senior Health Services Department was established at the St. Louis Park Medical Center, consisting of geriatric nurse practitioners, a social worker, and primary physicians. MedCenter staff attributed its early low enrollment to an unexpectedly high level of confusion and skepticism on the part of Medicare beneficiaries regarding

the Demonstration program. Like HMOM, MedCenter has increased its marketing efforts in recent months, and these efforts seem to be having positive benefits.

Nicollet-Eitel, like SHARE and Med-Center, screened membership in its high option plan and accepted most applicants (approximately 80% of the applicants in the first year of the Demonstration). Staff members reported essentially the same types of problems that were reported elsewhere. Nicollet-Eitel did no promotion beyond the activities organized by Interstudy, which seems to account, in part, for their low enrollment.

Due to the competitive nature of the marketplace in the Twin Cities, relatively little information is available regarding the financial performance of the Demonstrations. SHARE's strategy of using a much more aggressive marketing strategy than the other HMOs paid off in terms of higher enrollment, and Plan management report that the program has been a financial success as well.

Other interesting developments involving the Interstudy Demonstration include the merger of Med-Center and Nicollet-Eitel Health Plans as of July 1, 1983. The major reasons cited for the merger are to bring about economies of scale and reduce overhead costs, in order to allow the combined plan to strengthen its competitive edge in the marketplace. The Medicare Demonstration continues at the Plan.

Finally, in the fall of 1983, Group Health Plan, Inc. of Minnesota became a participating HMO in the Interstudy Demonstration. Group Health is a large, staff model HMO with about 200,000 members. The Interstudy Demonstration Project contract, including Group Health, has been extended for two years through December 1985. Therefore, the level of competitive activity among the Demonstration HMOs in Minneapolis/St. Paul is likely to be enhanced, resulting in continued growth in enrollment for the Demonstration HMOs.

E. Health Central

The history of Health Central is very important to understanding their approach to the Medicare Demonstration Project. Health Central, which was incorporated in 1975 and organized as a staff model HMO, began enrolling members in January 1978. Large groups (e.g., General Motors, Michigan State University, and the State of Michigan) were very receptive to Health Central. Enrollment in Health Central grew to 4,000 members by August of 1978. In the following two months, 12,000 more people enrolled with enrollment reaching 21,000 by the end of the year. This very rapid increase in enrollment outstripped Health Central's capacity to serve its membership. To accommodate this demand, Health Central referred enrollees to non-plan providers at full fee-for-service costs, resulting in the loss of control over utilization and cost.

By the spring of 1979, large operating deficits were uncovered by Michigan's Insurance Commission. The Insurance Commissioner ordered that Health Central be placed into receivership. A subsequent audit by the Office of Health Maintenance Organizations resulted in a declaration of non-compliance. During this time, efforts were being made to find new owners for the financially troubled organization. In August 1979, Blue Cross and Blue Shield of Michigan (BCBSM) agreed to purchase all assets and assume complete management control of Health Central.

While Health Central lost approximatley 40% of its membership over the next several months, the Plan reached a turning point. BCBSM brought an entirely new management team into Health Central, introduced an integrated system of utilization control to the organization, and gradually brought stability and financial viability to Plan operations.

Under its new owner, fiscal conservation dominated decision-making at Health Central. While Health Central's proposal for a Medicare Demonstration Program was approved around the time of the BCBSM takeover, BCBSM did not give high priority to implementing the pro-

gram due to the inherent risk of treating the Medicare population on a prepaid basis. Deciding to proceed with the Demonstration, BCBSM management staff felt strongly that a risk sharing arrangement should be negotiated with HCFA. It took approximately one year to negotiate such an arrangement, and the first date of effective enrollment in the Demonstration was January 1982. Growth in Demonstration enrollment has since been purposefully slow in order to maintain control over the program and to avoid any major shocks to the organization.

While there have been some changes in administrative and operational aspects of Health Central's delivery system as a result of the Medicare Program, the organizational changes have been minimal. The reasons are as follows:

- BCBSM took a slow, cautious approach to development of the Medicare program as a result of the Plan's early financial problems.
- Growth in enrollment has been gradual, which has allowed the Plan to respond to problems and issues before any severe impact is felt.
- An aggressive system of utilization control was instituted by Blue Cross when it assumed ownership of Health Central. To date, there have been no utilization control problems exposed by the Demonstration, as occurred at other Demonstration sites.

Marketing of the Demonstration was found to be more difficult than anticipated due to the individual approach to prospective members, and to the fact that a large premium increase in Blue Cross Medicare Supplementary Coverage did not materialize, resulting in a smaller than expected premium differential between Blue Cross and Health Central. Enrollment targets of 100-150 new members per month have not been met, and as of March 1, 1983, Health Central had 549 Medicare members.

Though the Medicare Program has been small in terms of enrollment, it has contributed to the overall financial success of Health Central. The Plan returned to a surplus operating position prior to the

Demonstration. However, since the Demonstration, the magnitude of the operating surplus has grown. For this reason, Health Central staff are supportive of the slow, deliberate approach to developing a Medicare risk program in an organization that has not previously served this population. Having gained operational experience, Health Central expects to increase its marketing emphasis and grow more rapidly in the near future.

The Medicare Demonstration at Health Central has produced some innovative changes. The most significant is development of an Intake Interview for Medicare members, which includes the following: taking a patient history, selecting a physician, requesting old medical records, scheduling a first appointment, and otherwise orienting the beneficiary to the new program. All staff at Health Central speak of the beneficial impact that this program has had on the Medicare Program.

Health Central has a very well developed utilization review function, including pre-admission interviews, concurrent review in the hospital, discharge planning, use of home health services, and an assessment process for complicated cases. Health education services are also emphasized by the Plan. Though none of these programs was developed exclusively for the Medicare Program, the Demonstration has accentuated their importance.

In the marketing and administrative areas, Health Central is moving to a quarterly enrollment process in order to focus marketing activities into finite periods of each year. The Plan intends to place a marketing individual dedicated to the Medicare Program in a visible part of the health center. Other changes include some modifications to the management information system and emphasis upon utilization reporting in order to maintain management control.

In the first year and a half of the Demonstration, operational activities at Health Central have evolved slowly. This is in contrast to the more dramatic impact that has been observed at the other demons-

tration sites. The deliberate approach employed by BCBSM has worked to the benefit of Health Central, and to the extent that these positive results can be duplicated at other HMOs, this is a developmental approach worthy of note.

APPENDICES

LIST OF APPENDICES

APPENDIX A

MEDICARE PROGRAM BENEFITS

Appendix A

Medicare Program Benefits*

Introduction

The Social Security Amendments of 1965 (Public Law 89-97) established a new program for health insurance for persons age 65 and older. This program (Title XVIII of the Social Security Act - Health Insurance for the Aged), popularly known as "Medicare", became effective on July 1, 1966. Public Law 92-603 extended Medicare coverage to two additional groups of beneficiaries, effective July 1, 1973; the disabled and individuals under 65 with chronic renal disease. Together, with the 1967 Amendment to the Act, they provide a wide range of health services.

Hospital Insurance (Part A)

An individual who has applied for and has been determined to be entitled to monthly social security benefits or railroad retirement benefits (although he may not actually be receiving benefit payments, e.g., he has not retired) is automatically entitled to hospital insurance (Part A of the law) beginning with the first day of the month he attains age 65. A special provision of the law permits persons age 65 and over, who do not qualify for monthly social security or railroad benefits, to obtain hospital insurance upon filing an application, enrolling in SMI, and paying a monthly premium for Part A coverage.

Beneficiaries who are under age 65 and who have been entitled to disability benefits under either the Social Security or Railroad Retirement Act for at least 24 consecutive months are automatically entitled to hospital insurance (Part A of Medicare) beginning with the first day of the 25th month.

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*Source: HCFA Interim Operating Instructions for HMOs, Chapter 1.

In addition, certain individuals under age 65 who require kidney transplantation of dialysis will automatically become entitled to hospital insurance (Part A) on the first day of the month in which they meet all the requirements of the provisions of the law. (See section 100.3)

Part A coverage includes 90 days of inpatient hospital services in each benefit period, as well as a lifetime reserve of 60 days which can be used during any benefit period; up to 100 days of covered inpatient extended care services in each benefit period; and up to 100 home health visits within a benefit period. A benefit period or "spell of illness" is a period of consecutive days that begins with the first day on which a beneficiary is furnished inpatient services in a qualified hospital or skilled nursing facility and ends with the close of 60 consecutive days during which the beneficiary has not been an inpatient in a hospital or skilled nursing facility.

Supplementary Medical Insurance (Part B)

To obtain medical insurance (Part B) coverage, an individual must voluntarily enroll in the plan and pay the required premium.

The Supplementary Medical Insurance (SMI) plan is designed to supplement the basic coverage of the hospital insurance plan by providing reimbursement (after a yearly deductible prescribed by law has been met) for 80 percent of the reasonable charge (or of the reasonable cost if the service is furnished by a participating provider of services) for the following specified medical and other health services:

A. Physician's services, including surgery, consultation, home, office, and institutional calls, and services and supplies furnished incident to a physician's professional service;

B. Outpatient hospital services furnished incident to physicians' services;

C. Outpatient diagnostic services furnished by a hospital;

D. Outpatient physical therapy;

E. Diagnostic X-ray tests, laboratory tests, and other diagnostic tests;

F. X-ray, radium, and radioactive isotope therapy;

G. Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations;

H. Rental or purchase of durable medical equipment for use in the patient's home;

I. Ambulance service;

J. Prosthetic devices which replace all or part of an internal body organ;

K. Leg, arm, back, and neck braces and artificial legs, arms, and eyes; and

L. Up to 100 home health visits in a calendar year.

Renal Disease Provision of Medicare

Individuals under age 65 who need hemodialysis or renal transplantation for chronic renal disease are eligible for hospital insurance under Medicare and for enrollment in the medical insurance program if they: a) meet certain work requirements for insured status under the social security program, b) are entitled to monthly social security benefits, or c) are the spouses or dependent children of an individual falling into either category (a) or (b).

Eligibility for coverage begins with either the month in which the patient is hospitalized in preparation for and anticipation of kidney transplant surgery, provided that such transplant surgery occurs in

that month or the following month, or with the third calendar month after the month in which the patient begins a course of dialysis, whichever is earlier.

An individual's entitlement established under the Chronic Renal Disease provision ends with the twelfth month after the month in which he receives a kidney transplant or such course of dialysis is otherwise terminated, unless before the end of such twelfth month, the individual again requires a course of dialysis of a kidney transplant.

Disability Insurance Provision of Medicare

Beneficiaries under 65 who have been entitled to disability benefits under either the Social Security or Railroad Retirement Act for at least 24 consecutive months will automatically be entitled to hospital insurance and may enroll in the medical insurance program.

Hospital insurance and SMI coverage for beneficiaries under age 65 who qualify under the disability insurance provision will terminate with the month the disability benefit terminates or, if later, the month following the month that a notice of disability termination is mailed to the beneficiary.

Some patients with chronic renal disease who meet the above requirements may become entitled to Medicare under the disability insurance provision of the law provided their first month of eligibility under this provision would be equal to or earlier than the first month they could become eligible under the chronic renal disease provision.

DEDUCTIBLES AND COINSURANCE

Part A - Inpatient Hospital Benefits

For the first 60 days of hospitalization in each benefit period, hospital insurance (Part A) pays for all covered services except for an initial deductible. From the 61st through the 90th day, hospital insur-

ance pays for all covered services except for a daily coinsurance amount of $76.00 per day.

When a beneficiary uses any of his lifetime reserve days (the 60 additional hospital days) hospital insurance pays for all covered services except for a daily coinsurance amount of $152.00 per day.

Skilled Nursing Facilities Benefits

Hospital insurance pays for all covered services in a participating skilled nursing facility for the first 20 days in each benefit period. There is a daily coinsurance amount for the 21st through 100th day in the same benefit period. The current daily copayment is $38.00.

Part B - Supplementary Medical Insurance

Except for special limitations, (see section 404), Medicare will pay 80 percent of reasonable charges for covered medical expenses after an initial deductible of $75.00 is paid. The deductible must be met in each calendar year.

APPENDIX B

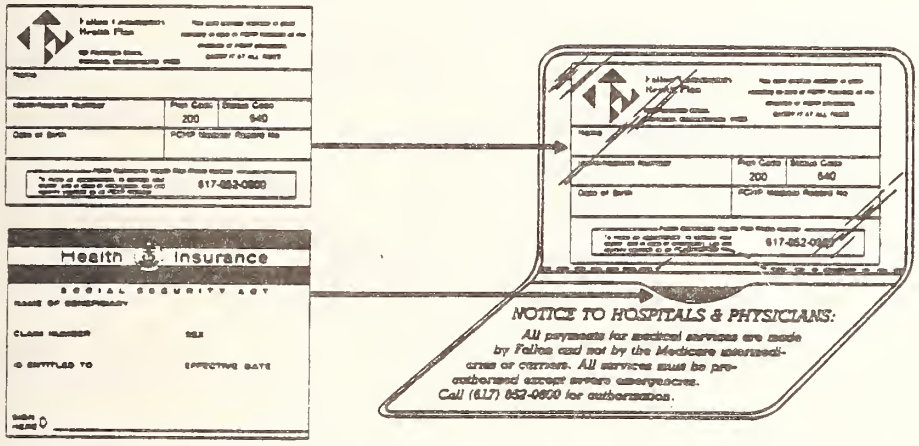
FALLON IDENTIFICATION CARDHOLDER

EXHIBIT N

Fallon Community
Health Plan

Dear Senior Plan Member,

Here is a specially designed holder for your Fallon card and Medicare card. Place your Fallon card on the clear plastic side of the holder and your Medicare card on the other side:



Always present your FALLON identification card whenever you seek medical care.

REMEMBER: You must call the Plan before seeking medical care except in severe life threatening emergencies, or when you are outside the Worcester area and a sudden onset of a condition requires immediate medical attention. The Senior Plan and Medicare will not pay for services not authorized or performed by Fallon Clinic physicians. If you have any questions, please call me at 852-4111.

Sincerely,

Marcia Callahan

Marcia Callahan
Senior Plan Representative

APPENDIX C

"JUST A FRIENDLY REMINDER"

Fallon Community Health Plan

JUST A FRIENDLY REMINDER

As a Senior Plan member you are entitled to complete Health Care Services.

BUT REMEMBER:

1. All of your health care must be provided by a Fallon Clinic physician.
2. If you do not have a Fallon doctor, call the appointment secretaries and schedule a visit. They will be happy to help you select a physician.

IMPORTANT TELEPHONE NUMBERS:

For EMERGENCIES call:	852-0600
For APPOINTMENTS call:	
Fallon Clinic, Worcester	852-0600
Fallon Medical Center/Auburn	832-9621
Fallon Medical Center/Westboro	366-8836

URGENT CARE:

In-Area:

If you have a medical emergency CALL THE FALLON CLINIC at 852-0600. If necessary, an appointment will be scheduled for you to be seen that day.

Out-of-Area:

If you are away from the Plan service area when an emergency occurs, requiring immediate medical or surgical attention, go to the nearest medical facility. You must call the Plan within 48 hours of receiving services.

LIFE-THREATENING EMERGENCY:

You may go to the nearest facility only if:

1. you are unable to call the Plan for reasons such as shock or unconsciousness or;
2. your life would be threatened if you did not receive immediate care and distance prevents you from reaching a Plan affiliated facility.

Life-threatening conditions include heart attacks, strokes, poisoning, bleeding and convulsions.

ANY QUESTIONS??

PLEASE CALL US WEEKDAYS 8:30 a.m. to 5:00 p.m.

852-4111

APPENDIX D

FALLON MEDICARE NEWSLETTER

SENIOR SPOTLIGHT

VOL. 2, NO. 1 | GOOD HEALTH: You're Old Enough to Enjoy It | SEPTEMBER, 1982

SENIOR PLAN- No Rate Increase in '83!

by Marcia R. Callahan
Senior Plan Marketing Specialist

The Fallon Senior Plan is entering its fourth year of operation; six thousand two hundred (6,200) members are presently enrolled with an additional 500 new members anticipated for 1983.

Members and area employers should be pleased to learn that the membership dues of $15.00 each month (or $45.00 each quarter) will remain unchanged through 1983. There are no benefit changes.

"The commitment of the Senior Plan continues to be," according to Dr. John Meyers, President of the Fallon Community Health Plan and Senior Plan's first member, "to provide Worcester-area Senior Citizens with the highest quality health care at the lowest possible cost to them. We've held the line on cost-$15.00 per month in '82; $15.00 per month in '83! Our philosophy is that if you don't feel well, you should be able to see your doctor without having to worry about how much it will cost."

It is with this philosophy in mind, that we look forward to continuing to provide medical services to you in the coming year.

Dr. John Meyers, President of the Fallon Community Health Plan, and first member of the Senior Plan.

UPDATE: "Urgent" vs. "Emergency" Problems

At a recent Senior Plan Advisory Council Meeting, several council members requested more information about how to distinguish an urgent problem from a life-threatening emergency.

An "*urgent*" problem is one which requires *prompt* medical attention, but is not life-threatening. Examples are head injuries (without loss of consciousness), cuts requiring stitches, a broken limb or abdominal pain. Whenever such an urgent problem does occur, call your Fallon physician. Arrangements will be made for your care. All Fallon locations

Continued on other side

Government Grants Senior Plan Extension

by Daniel Wolfson
Senior Plan Project Director

The Fallon Community Health Plan recently received a three-year extension of the Senior Plan contract. This means that the government will permit the Senior Plan program to continue at least until December 31, 1985. Furthermore, legislation has just passed so that Senior Plan may continue many more years at Fallon and at other HMOs throughout the country. We can all be proud that this experimental project was *the* pioneer Senior Plan program—a model for the nation.

Thanks to you, our members, the Senior Plan is an overwhelming success. I am confident it will continue to be successful in the future.

Daniel Wolfson.
Senior Plan Project Director.

OPEN ENROLLMENT AUGUST 1 - OCTOBER 10, 1982

It's that time of year again! From August 1 through October 10, 1982, Senior Plan will host its open enrollment. Here's what this means to you:

- If you wish to keep your present coverage- you don't have to do anything!
- If your friends wish to *join* Senior Plan, please have them call us at 852-4111.
- If you wish to *change from* Senior Plan, please call us at 852-4111.
- If you have coverage through an employer and you wish to make a change, please contact your employer group.

We encourage our members to tell their friends about the Senior Plan. They may attend an Open House, Sunday, September 19th, at 12 noon, and Sunday, October 17th at 12 noon. The Open Houses will be held at the Fallon Clinic, 630 Plantation St., Worcester, Ma.

Any comments, questions or suggestions on the SENIOR SPOTLIGHT are welcome—contact Sheila Burns Archdeacon, Editor.

ST. VINCENT HIGHLIGHTS

St. Vincent Hospital, the hospital most often used by Senior Plan for its members, is unique in many ways. Here is some information you might not yet know about St. Vincent!*

- It is the largest community teaching and research hospital in Central Massachusetts, having grown from an original 12 beds to 578 beds.
- It is the only hospital in the region to use a linear accelerator, a very sophisticated machine used in the treatment of cancer.
- It is headquarters for the National Institute for Health's Bladder Cancer Project.
- It is a recognized teaching hospital for medical students, nurses and respiratory technicians.
- It is the Spinal Cord Trauma Center for Central Massachusetts.

**All information courtesy of H. Furhman, St. Vincent Public Relations Department.*

UPDATE: Urgent/Emergency

Continued from page 1

treat urgent problems. In addition, Worcester's Urgent Access Unit is staffed week nights, weekends, and holidays.

A *life-threatening emergency* requires immediate medical care. Examples of such emergencies include severe chest pain, loss of consciousness, or uncontrollable bleeding. In such instances, getting the patient to the nearest emergency room is most important. We prefer the use of St. Vincent Hospital whenever possible. Fallon Clinic should be called as soon as possible. *Ambulance service is provided in a life-threatening situation;* it may be provided for an urgent problem upon a Fallon physician's request and authorization.

We hope your questions about Urgent and Emergency problems have been answered. If you still have questions, please call us.

SURVEYS FOR SENIORS

Some Senior Plan members will soon be asked for their opinions about the Fallon Community Health Plan in a survey mailed to selected members' homes by us. We thank you for responding to it.

Later in the fall, some of you may be visited by persons from the Research Triangle Institute regarding another survey. The Federal Government is sponsoring a survey of Medicare beneficiaries in this area in order to evaluate the health care they receive. The survey will include members of the special Medicare program at Fallon-the Senior Plan. We have reviewed the survey and encourage any of our members who are asked to participate to do so.

The survey is called the Medicare Health Survey. It is being conducted by the Research Triangle Institute of North Carolina for the Health Care Financing Administration (HCFA), the Federal agency responsible for administration of the Medicare program.

All interviewers will be from this area. They will carry identification cards with their photographs on them, issued by the Research Triangle Institute. They will also have with them a copy of the introductory letter from HCFA. This is for your protection.

While participation in the survey is voluntary, a high rate of participation among selected persons is needed. This makes the survey results more accurate. We believe that this is a worthwhile survey. Thank you for your help!

October is Health Education Month at Fallon Clinic

APPENDIX E

SAMPLE MARKETING MATERIALS

Share SeniorCare

Schedule Of Benefits

Here's information about the Health Maintenance Organization (HMO) that covers nearly all your health care needs when you're eligible for Medicare.

When you choose SeniorCare:

- Medicare makes SHARE the administrator of your Medicare benefits.
- SHARE combines your Medicare benefits with your SHARE benefits and assumes responsibility for nearly all your medical needs.
- You no longer worry about the paperwork of separate Medicare-and-insurance-supplement programs.
- You can forget about coverage "gaps" between two separate programs.
- SHARE assures you complete, quality care without fear that unexpected medical costs can cause financial disaster.
- SHARE is your partner in sickness and in health.

SHARE SeniorCare

Schedule Of Benefits

Benefits and Services

Rates subject to change annually.

	SHARE SeniorCare High Option Plan ($19.75 per month)	Your Present Medicare Coverage
Hospital Inpatient Care	**The SHARE High Option Plan covers unlimited hospital days at no cost to you.**	
• Semi-private room, meals, special diets	PAID in full (unlimited days)	Coverage limited to 90 days per benefit period. First 60 days, you pay $260. For 61-90 days you pay $65 per day. Then for 60-day lifetime reserve you pay $130 per day.
• Operating room, special care units	PAID in full (unlimited days)	
• Nursing services	PAID in full (unlimited days)	
• Drugs furnished by the hospital	PAID in full (unlimited days)	
• Laboratory tests	PAID in full (unlimited days)	
• X-ray tests and other radiology services	PAID in full (unlimited days)	
• Necessary medical supplies and use of appliances	PAID in full (unlimited days)	
• Medical social services	PAID in full (unlimited days)	
• Blood and its administration	PAID in full (unlimited days)	
Skilled Nursing Facility Care*	**365 days per benefit period. No 3-day hospitalization stay requirement.**	
• Semi-private room, meals, special diets	PAID in full	Limited to 100 days per benefit period only if following hospitalization stay of at least 3 days. First 20 days covered in full. For 21-100 days, you pay $32.50 per day.
• Nursing services	PAID in full	
• Drugs furnished by the skilled nursing facility	PAID in full	
• Physical, occupational, and speech therapy	PAID in full	
• Necessary medical supplies	PAID in full	
• Use of appliances and equipment furnished by the facility, such as a wheelchair, crutches, and braces	PAID in full	
• Medical social services	PAID in full	
*Does not include custodial or domiciliary care.		
Outpatient Care	**No deductibles, no co-insurance for covered services.**	
Physician and other services:		
• Office Visits	PAID in full	$75 deductible per calendar year. Then 80% coverage of Medicare allowable charge. (Medical services often cost more than Medicare's allowable charge.)
• Medical and surgical care	PAID in full	
• Diagnostic tests and treatment	PAID in full	
• Laboratory and x-ray tests	PAID in full	
• Dressings, splints, and casts	PAID in full	
• Physical therapy	PAID in full	
• Speech pathology	PAID in full	
• Durable medical equipment	PAID in full	
• Inpatient physician and surgical services	PAID in full	
• Radiation therapy	PAID in full	
• Ambulance service (when authorized)	PAID in full	
• Dental care only for surgery of the jaw or related structures	PAID in full	
• Prosthetic devices, heart pacemakers, braces, artificial limbs and eyes	PAID in full	
• Drugs and biologicals which cannot be self-administered	PAID in full	

Preventive Health Care Services:		Routine preventive health care services are not covered by Medicare.
• Routine physical exams	PAID in full	
• Routine hearing exams	PAID in full	
• Routine eye exams	PAID in full	
• Routine foot care	PAID in full	
• Immunizations	PAID in full	

Home Health Care

	Unlimited Visits	**Unlimited Visits**
• Part-time skilled nursing care	PAID in full	
• Part-time home health aide care	PAID in full	
• Physical, speech and occupational therapy	PAID in full	Covered in full
• Medical social services	PAID in full	
• Medical supplies and equipment provided by the home health agency	PAID in full	

Mental Health Care

Psychiatric inpatient hospital care in a psychiatric hospital for crisis intervention and short term psychotherapy.	Covered in full for first 60 days; for the 61st through the 90th day, you pay a $15 per day co-payment. Limited to 90 days per benefit period with a 190-day lifetime limit.	Coverage same as Hospital Inpatient Care with 190-day lifetime limit.
Services of psychiatrists, psychologists, and mental health counselors.	Up to 20 outpatient visits per year with a $5 per visit co-payment.	$75 deductible. Limited to $250 per calendar year

Emergency Services Or Urgently Needed Services Anywhere In The World

• At Plan Hospital after clinic hours	You pay a $10 co-payment.	Same coverage as hospital and medical services above.
• At a Non-Plan Hospital	You pay 20% of the first $500. SHARE pays the balance within specified Hospital/Physician benefits summarized above.	

Emergency Services include those benefits under this Plan, received inside or outside the SHARE service area, for an accident or illness of a serious nature which threatens the life or serious impairment of the member's health.

Urgently Needed Services include benefits covered under this Plan (while temporarily outside of SHARE's service area) for an accident or illness of a less serious nature (than those described under Emergency Services) which (a) are required in order to prevent a serious deterioration in the member's health, and (b) which cannot be delayed until the enrollee returns to the service area. A "temporary absence" from the service area is defined as less than 120 days.

Services and Supplies Not Covered

- Dental care, except as described in YOUR MEDICARE HANDBOOK
- Outpatient prescription drugs
- Cosmetic surgery
- Injection which can be self-administered
- Personal or comfort items during inpatient care (i.e., T.V., telephone, etc.)
- Eyeglasses, except as described in YOUR MEDICARE HANDBOOK
- Hearing aids or dentures
- Orthopedic shoes (unless part of brace) or foot supports
- Acupuncture
- Home Health Care does not include housekeeping or custodial care
- Private duty nursing
- Care for military service connected disabilities for which enrollee is legally entitled to services from other available provider resources
- Experimental health care procedures
- Services which are not reasonable or necessary f the treatment of an illness
- Mental Health care is limited to crisis interventio short-term therapy and evaluation only. Long-ter mental health care is not covered
- Hospitalization for rest cures or convalescence i nursing homes

• Hearing aids or dentures

SHARE SeniorCare: Complete full-service Medical Centers plus access to fine Twin Cities hospitals.

UNITY HOSPITAL
550 Osborne Rd.
Fridley

BROOKLYN PARK MEDICAL CENTER
5805 74th Ave. No.
Brooklyn Park

COLUMBIA PARK CLINIC
3620 Central Ave. N.E.
Minneapolis

FAIRVIEW-SOUTHDALE HOSPITAL
6401 France Ave. So.
Edina

STADIUM SQUARE MEDICAL CENTER
7920 Cedar Ave. So.
Bloomington

New for 1982:
RICE STREET CLINIC
1006 Rice St.
St. Paul

BETHESDA HOSPITAL
559 Capitol Blvd
St. Paul

ST. PAUL MEDICAL CENTER
555 Simpson St.
St. Paul

MIDWAY HOSPITAL
1700 University Ave.
St. Paul

PLAN HOSPITALS

Members must use their plan hospitals except during emergencies or when referred by their SHARE doctor. Your Plan Hospital is determined by your clinic choice. If you select the St. Paul Medical Center, you will use Midway Hospital. Members of the Stadium Square Medical Center will use Fairview-Southdale Hospital. Members of the Columbia Park Clinic and the Brooklyn Park Medical Center will use Unity Hospital. Members of the Rice Street Clinic will use Bethesda Hospital.

You are eligible to join SHARE SeniorCare if:

- **You are enrolled in the Federal Medicare Program hospital insurance "Part A" and the medical insurance "Part B."**
- **You reside in SHARE's service area: the seven counties of Ramsey, Hennepin, Anoka, Washington, Dakota, Scott and Carver.**
- You do not have Chronic or End Stage Kidney Disease.
- You are not on the Medical Assistance (Welfare) Program.
- The SHARE SeniorCare Plan requires completion of a health questionnaire subject to SHARE's acceptance.

SHARE will provide nearly all your care.

The health services and benefits under SeniorCare are provided to you through a special SHARE/Medicare contract. The current contract covers a three-year period through December 31, 1983. A new contract with similar or improved benefits will provide continuous coverage after December 1983.

To be entitled to these SeniorCare/Medicare benefits, **you must use the SHARE SeniorCare medical staff and facilities, unless medical care is required under emergency or urgently needed conditions.** If you need special services not available at your SHARE Clinic, your SHARE doctor will arrange for necessary care covered under this program. **Only those services provided by, or arranged through your SHARE doctor will be covered by SHARE or Medicare (except for emergency or urgently needed services as stated above).**

SHARE wants to make sure you'll be satisfied.

When you become a member of SHARE, we hope you will give us your comments and suggestions so that we may continue to improve our service to you. While we hope there are no problems with our services, one occasionally arises. In this case, we do have a complaint procedure, created to resolve your problem as rapidly and efficiently as possible. Depending on the nature of the problem, the administrative staff or the Medical Director or the Board of Directors will review your complaint to provide you with a satisfactory resolution. If you are still not satisfied, you may appeal to the Social Security Administration.

Disenrollment Rights.

SHARE may disenroll a SeniorCare member only under the following conditions:

1. Failure by the member to pay a premium or co-payment when necessary
2. A member's moving from the SHARE Service Area
3. Death
4. Loss of entitlement by the member of Medicare Part A or Part B coverage
5. Fraudulent statements by the member during the application process

You may disenroll voluntarily at any time with a 30-day written notice to SHARE.

For more information or enrollment packet, call or write now.

SHARE SeniorCare

7920 Cedar Avenue South
Bloomington, Minnesota 55420

854-2377

In Coordination with the Metropolitan Senior Federation

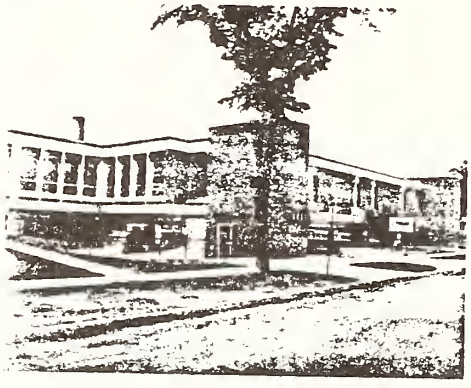
share

INTRODUCES THE

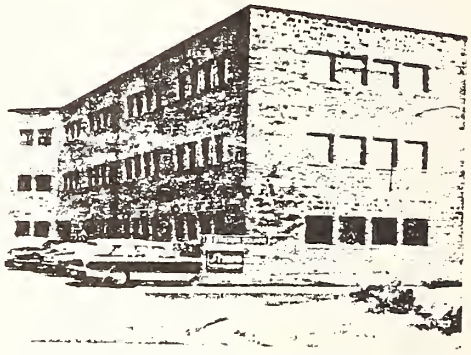
SeniorCare PLAN

A Program to Supplement Medicare Benefits

The SHARE SeniorCare Plan is a new kind of Health Care Plan that provides and pays for comprehensive health care and preventative health services. SHARE, a federally qualified health maintenance organization (HMO) is similar to health insurance but with a big difference. SHARE delivers medical service through its own doctors and facilities to over 35,000 members. In short, it is a combination of health insurance and the delivery of medical care.



St. Paul Medical Center
555 Simpson Street
(Near University & Snelling)
St. Paul, MN 55104



Stadium Square Medical Center
7920 Cedar Avenue South
Bloomington, MN 55420

Columbia Park Clinic
3620 Central Avenue N.E.
Minneapolis, MN 55418

Brooklyn Park Medical Center
5805-74th Avenue North
Brooklyn Park, MN 55443

BENEFITS AND SERVICES	SHARE SENIORCARE HIGH OPTION PLAN ($14.95 per month)	SHARE SENIORCARE BASIC PLAN ($13.95 per month)
HOSPITAL INPATIENT CARE	**The SHARE High Option Plan covers *unlimited* hospital days at no cost to you.**	**The SHARE Basic Plan covers all deductibles and co-insurance but limits hospital care to 90 days per benefit period (plus lifetime reserve available from Medicare).**
■ Semi-private room, meals, special diets	covered in full (unlimited days)	covered in full (up to 90 days)
■ Operating room, special care units	covered in full (unlimited days)	covered in full (up to 90 days)
■ Nursing services	covered in full (unlimited days)	covered in full (up to 90 days)
■ Drugs furnished by the hospital	covered in full (unlimited days)	covered in full (up to 90 days)
■ Laboratory tests	covered in full (unlimited days)	covered in full (up to 90 days)
■ X-ray tests and other radiology services	covered in full (unlimited days)	covered in full (up to 90 days)
■ Necessary medical supplies and use of appliances	covered in full (unlimited days)	covered in full (up to 90 days)
■ Medical social services	covered in full (unlimited days)	covered in full (up to 90 days)
■ Blood and its administration	covered in full (unlimited days)	covered in full (up to 90 days)
SKILLED NURSING FACILITY CARE	**365 days per benefit period.***	**100 days per benefit period.***
■ Semi private room, meals, special diets	covered in full	covered in full
■ Nursing services	covered in full	covered in full
■ Drugs furnished by the skilled nursing facility	covered in full	covered in full
■ Physical, occupational, and speech therapy	covered in full	covered in full
■ Necessary medical supplies	covered in full	covered in full
■ Use of appliances and equipment furnished by the facility, such as a wheelchair, crutches, and braces	covered in full	covered in full
■ Medical social services	covered in full	covered in full
OUTPATIENT CARE	**No deductibles, no co-insurance for covered services.**	**No deductibles, no co-insurance for covered services.**
Physician Services Include:		
■ Routine physical exams	covered in full	not covered
■ Routine hearing exams	covered in full	not covered
■ Routine eye exams	covered in full	not covered
■ Routine foot care	covered in full	not covered
■ Immunizations	covered in full	covered in full
■ Medical and surgical care	covered in full	covered in full
■ Diagnostic tests and treatment	covered in full	covered in full
■ Laboratory and x-ray tests	covered in full	covered in full
■ Dressings, splints, and casts	covered in full	covered in full
■ Physical therapy	covered in full	covered in full
■ Speech pathology	covered in full	covered in full
■ Durable medical equipment	covered in full	covered in full
Other Services and Supplies Include:		
■ Inpatient physician and surgical services	covered in full	covered in full
■ Radiation therapy	covered in full	covered in full
■ Ambulance service (when authorized)	covered in full	covered in full
■ Dental care only for surgery of the jaw or related structures	covered in full	covered in full
■ Prosthetic devices, heart pace-makers, braces, artificial limbs and eyes	covered in full	covered in full
■ Drugs and biologicals which cannot be self administered	covered in full	covered in full

*Medicare requirement for a 3-day hospital stay is waived.

Rates subject to change annually.

BENEFITS AND SERVICES	SHARE SENIORCARE HIGH OPTION PLAN ($14.95 per month)	SHARE SENIORCARE BASIC PLAN ($13.95 per month)
HOME HEALTH CARE	***Up to 250 visits per benefit period (125 visits each for Part A and Part B)**	***Up to 200 visits per benefit period (100 visits each for Part A and Part B)**
■ Part-time skilled nursing care	covered in full	covered in full
■ Part-time home health aide care	covered in full	covered in full
■ Physical, speech and occupational therapy	covered in full	covered in full
■ Medical social services	covered in full	covered in full
■ Medical supplies and equipment provided by the home health agency	covered in full	covered in full

*Medicare requirements for three-day hospital stay is waived.

MENTAL HEALTH CARE

■ Psychiatric inpatient hospital care in a psychiatric hospital for crisis intervention and short term psychotherapy.	covered in full for first 60 days; for the 61st through the 90th day, you pay a $15/day co-payment. The High Option Plan is limited to 90 days per benefit period with a 190 day lifetime limit.	covered in full for first 60 days; for 61st through the 90th day, you pay a $25/day co-payment. The Basic Plan is limited to 90 days per benefit period with a 190 day lifetime limit.
■ Services of psychiatrists, psychologists, and mental health counselors.	Up to 20 outpatient visits per year with a $5/visit co-payment.	up to 10 outpatient visits per year with a $10/visit co-payment.

*EMERGENCY SERVICES OR **URGENTLY NEEDED SERVICES

■ At Plan Hospital after clinic hours	you pay a $10 co-payment.	you pay a $10 co-payment.
■ At a Non-Plan Hospital	you pay 20% of the first $500 SHARE pays the balance within specified Hospital/Physician benefits summarized above	you pay 20% of the first $500 SHARE pays the balance within specified Hospital/Physician benefits summarized above

***EMERGENCY SERVICES include those benefits under this Plan, received inside or outside the SHARE service area, for an accident or illness of a serious nature which threatens the life or serious impairment of the member's health.**

****URGENTLY NEEDED SERVICES include benefits covered under this Plan (while temporarily outside of SHARE's service area) for an accident or illness of a less serious nature (than those described under Emergency Services) which (a) are required in order to prevent a serious deterioration in the members health, and (b) which cannot be delayed until the enrollee returns to the service area. A "temporary absence" from the service area is defined as less than 120 days.**

PLAN HOSPITALS

Your Plan Hospital will be determined by your clinic choice. If you select the St. Paul Medical Center, you will use Samaritan Hospital. Members of the Stadium Square Medical Center will have access to Fairview Southdale Hospital and Samaritan Hospital. Members of the Columbia Park Clinic and the Brooklyn Park Medical Center use Unity Hospital.

SERVICES AND SUPPLIES NOT COVERED

- Dental care, except as described in YOUR MEDICARE HANDBOOK
- Outpatient prescription drugs
- Cosmetic surgery
- Injection which can be self-administered
- Personal or comfort items during inpatient care (i.e., T.V., telephone, etc.)
- Eyeglasses, except as described in YOUR MEDICARE HANDBOOK
- Hearing aids, or dentures
- Orthopedic shoes (unless part of brace) or foot supports
- Acupuncture
- Homemaker, custodial or domiciliary care
- Private duty nursing
- Care for military service connected disabilities for which enrollee is legally entitled to services from other available provider resources
- Experimental health care procedures
- Services which are not reasonable or necessary for the treatment of an illness
- Mental Health care is limited to crisis intervention, short-term therapy and evaluation only. Long-term mental health care is not covered.
- Routine physical exams, vision and hearing exams are not covered under the BASIC Benefit Plan
- Hospitalization for rest cures or convalescence in nursing homes

THE Share SeniorCare PLAN

OFFERS YOU A CHOICE OF A BASIC PLAN OR A HIGH OPTION PLAN

SHARE offers you a choice between two plans, depending on your budget and your anticipated needs. Both of these SeniorCare Plans cover all deductibles and co-insurance costs you now pay under Medicare. THE HIGH OPTION PLAN also offers:

- **Unlimited Hospital Days, covered in full.**
- **Unlimited skilled nursing care, covered in full up to 365 days per benefit period.**
- **Full coverage for: Routine physicals, hearing and eye exams, and foot care.**

TO BE ELIGIBLE

YOU ARE ELIGIBLE TO JOIN SHARE'S SENIORCARE PLAN IF:

- **You are enrolled in the Federal Medicare Program hospital insurance "Part A" and the medical insurance "Part B."**
- **You reside in SHARE's service area: the five counties of Ramsey, Hennepin, Anoka, Washington and Dakota.**

NOTE: The SHARE SeniorCare Plan requires completion of a health questionnaire subject to SHARE's acceptance.

REQUIRED USE OF SHARE FACILITIES FOR SENIORCARE/MEDICARE BENEFITS

The health services and benefits under SeniorCare are provided to you through a special SHARE/Medicare contract.* To be entitled to these SeniorCare/Medicare benefits, you must use the SHARE SeniorCare medical staff and facilities, **unless medical care is required under emergency or urgently needed conditions.**

If you need special services not available at your SHARE Clinic your SHARE doctor will arrange for necessary care covered under this program. **Only those services provided by, or arranged through, your SHARE doctor will be covered by SHARE or Medicare (except for emergency or urgently needed services as stated above).**

*The current contract covers a three-year period through December 31, 1983. A new contract with similar or improved benefits will provide continuous coverage after December 1983.

FOR YOUR SATISFACTION

When you become a member of SHARE, we hope you will give us your comments and suggestions so that we may continue to improve our service to you. While we hope there are no problems with our services, one occasionally arises. In this case, we do have a complaint procedure, created to resolve your problem as rapidly and efficiently as possible. Depending on the nature of the problem, the administrative staff or the Medical Director or the Board of Directors will review your complaint to provide you with a satisfactory resolution. If you are still not satisfied, you may appeal to the Social Security Administration.

DISENROLLMENT RIGHTS

SHARE may disenroll a SeniorCare member only under the following conditions:

1. Failure by the member to pay a premium or co-payment when necessary.
2. A member's moving from the SHARE Service Area,
3. Death,
4. Loss of entitlement by the member of Medicare Part A or Part B coverage, or
5. Fraudulent statements by the member during the application process.

You may disenroll voluntarily at any time with a 30 days' written notice to SHARE.

TO ENROLL OR FOR MORE INFORMATION:
SHARE SENIORCARE • 7920 Cedar Avenue South
Bloomington, Minnesota 55420
OR CALL 854-2377

Revised 11/80

A Full Service Health Plan
7920 Cedar Avenue South • Bloomington, Minnesota 55420 • (612) 854-2377

Dear Senior Citizen:

There is a way to keep pace with rising medical costs: SeniorCare. This special HMO/Medicare Plan is offered through the SHARE Health Maintenance Organization (HMO) which provides complete medical care through four medical centers and affiliated hospitals in the Metropolitan area. SeniorCare coverage is usually more comprehensive than Medicare Supplemental Insurance programs because there are no deductibles (except in emergency care), and no required waiting periods before pre-existing ailments. Most insurance policies do not cover existing problems from the time coverage begins. SHARE does!

SeniorCare, first made available in 1979, is also less expensive than many Medicare Supplemental insurances. SeniorCare's premiums did not increase the first two years it was offered. Premiums are $14.95 per month for the High Option Plan or $13.95 per month for the Basic Plan.

The application process requires both the Medical Questionnaire and Enrollment Form to be filled out completely and sent in to our Administrative Offices. An addressed envelope is enclosed for your convenience.

As a SHARE SeniorCare member, in order to receive your SHARE and Medicare benefits you must use the SHARE Plan facilities. Medicare benefits are available at non-SHARE Plan facilities in life-threatening or medically urgent emergencies.

We hope you'll choose SeniorCare now. For a limited time only, a special Get Acquainted Offer is available to you. If we receive your application before October 9, 1981,

You will receive the first month of SHARE SeniorCare

coverage FREE!

All the details are enclosed. We hope you'll read them carefully and find that SeniorCare is the plan for you.

With Best Wishes,

R.K. Dittmore
President
SHARE Health Plan

SHARE HEALTH PLAN MEDICAL STAFF

ST. PAUL MEDICAL CENTER

Surgery
Richard J. Webber, M.D.
Medical Director
Dale Anderson, M.D.
Cay Ann Chock, Physician Assistant

Internal Medicine
Keith Bakke, M.D.
Jack Beaird, M.D.
Thomas Dashiell, M.D.
(Pulmonary Disease)
Valerie Evje, M.D.
Lawrence Kaplan, M.D.
(Gastroenterologist)
Paul Kuhnmuench, M.D.
James Lillehei, M.D.
(Cardiologist, Pulmonary Disease)
Gordon Mosser, M.D.
John Rotilie, M.D.
Jarrold Smith, M.D.
David Walcher, M.D.
Marilynn Bast, Nurse Practitioner
Jeannine Bayard, Nurse Practitioner
Kathleen Eggink, Nurse Practitioner
Judith Johnson, Nurse Practitioner
Diane Schweizer, Nurse Practitioner
Jacqueline McLeod-Werket,
Nurse Practitioner

Pediatrics
Ewa Bleeker, M.D.
Jeff Brand, M.D.
David Griffin, M.D.
Theodore Hajek, M.D.
Arnold London, M.D.
Laura Saliterman, M.D.
Joan Buchanan, Nurse Practitioner
Jim Mann, Physician Assistant
Lynda Olson, Nurse Practitioner
Eileen Vinnes, Nurse Practitioner

Obstetrics & Gynecology
Laurence Nace, M.D.
Terry Scheid, M.D.
Barbara Washburn, Physician Assistant
Kathy Williams, Nurse Practitioner

Mental Health/Chemical Dependency
Metropolitan Clinic of Counseling
(five locations)

Ophthalmology/Optometry
Paul Erickson, O.D.
Michael Gesler, O.D.
David Kordish, O.D.
Lloyd Minaai, M.D.
Diane Tanabe, M.D.

Dermatology
Burrel Deaton, M.D.

Neurology
Paul Silverstein, M.D.
Bruce Idelkope, M.D.

STADIUM SQUARE MEDICAL CENTER

Surgery
Richard J. Webber, M.D.
Medical Director

Internal Medicine
Paul Dorsher, M.D.
David Pautz, M.D.
Lawrence Kaplan, M.D.
Randy Kimpell, M.D.
James Lillehei, M.D.
(Cardiologist, Pulmonary Disease)
Parin Winter, M.D.
Jeannine Bayard, Nurse Practitioner

Mental Health/Chemical Dependency
Metropolitan Clinic of Counseling
(five locations)

Pediatrics
Jeff Brand, M.D.
David Griffin, M.D.
Laura Saliterman, M.D.

Obstetrics & Gynecology
Laurence Nace, M.D.
Terry Scheid, M.D.
Kathy Williams, Nurse Practitioner

Ophthalmology/Optometry
David Kordish, O.D.
Lloyd Minaai, M.D.

BROOKLYN PARK MEDICAL CENTER

Family Practice

Myron E. Erickson, M.D.
Douglas J. Holt, M.D.
Donald E. Johnson, M.D.
Patrick A. Keenan, M.D.
Gary J. Miller, M.D.
Donald L. Wright, M.D.

Surgery

Frederick W. Johnson, M.D.

Internal Medicine

Steven C. Long, M.D.

Urology

Myung C. Park, M.D.

Obstetrics & Gynecology

Jose P. Montero, M.E.

Orthopedic Surgery

George A. Walker, M.D.

Mental Health/Chemical Dependency

Metropolitan Clinic of Counseling
(five locations)

COLUMBIA PARK CLINIC

Family Practice

James R. Bergan, M.D.
Charles L. Cohen, M.D.
Allen W. Delzell, M.D.
Myles E. Efteland, M.D.
Edson V. Fuglestad, M.D.
William R. Hilgedick, M.D.
Spencer A. Johnson, M.D.
Paul E. Mertens, M.D.
John C. Morgan, M.D.
John R. Ragan, M.D.

Surgery

Frederick W. Johnson, M.D.

Internal Medicine

Sim Gesundheit, M.D.
Steven C. Long, M.D.
Edward A. Spenny, M.D.

Urology

Myung C. Park, M.D.

Obstetrics & Gynecology

Jose P. Montero, M.D.

Physical Therapy

Bruce Bowman, R.P.T.

Orthopedic Surgery

George A. Walker, M.D.

Mental Health/Chemical Dependency

Metropolitan Clinic of Counseling
(five locations)

IMPORTANT NOTICE

In order to process your SeniorCare application <u>WE MUST HAVE A COPY OF YOUR MEDICARE CARD ENCLOSED WITH YOUR APPLICATION.</u>

By including this copy of your Medicare card with your application, we will be able to process your application more quickly. Thank you for your cooperation.

SHARE SeniorCare

Share

A Full Service Health Plan

7920 Cedar Avenue South
Bloomington, Minnesota 55420
(612) 854-2377

SeniorCare PLAN

MEDICAL QUESTIONNAIRE

- **Complete one questionnaire for each applican**
- **All questions must be answered**

Name _____ (First / Middle / Last) Date of Birth _____ Age____

Address _____ (Street / Apt. No. / City / MN / State / Zip Code)

Telephone No. _____ Medicare No. _____ (from Medicare Card)

Sex: ☐ F ☐ M Height:___ ft___ in Weight_____lbs. Marital Status: __Single __Married __Widowed

Have you been treated at Share in the last 10 years? ☐ Yes ☐ No Last Visit-Date: _____

Are you currently a member of an HMO? ☐ Yes ☐ No Name of HMO _____

Have you previously applied for Membership in Share? ☐ Yes ☐ No

Have you ever been rejected or rated for insurance? ☐ Yes ☐ No If yes, give reason & Date: _____

Are you capable of self-care? ☐ Yes ☐ No

Are you currently living at a nursing home or convalescent home? ☐ Yes ☐ No

Have you ever had or been treated for any of the following conditions:

Condition	Yes	No	Date Started	Date Ended	Condition	Yes	No	Date Started	Date Ended
Asthma					Allergy				
Lung Trouble					Back Trouble				
Heart Trouble					Alcoholism				
High Blood Pressure					Drug Abuse, Type				
Stomach Ulcers or Duodenal Ulcers					Nervous Condition				
Hernia					Psychiatric Problem				
Cataract(s)					Sugar Diabetes				
Bowel Trouble					Anemia				
Liver Trouble					Thyroid				
Gall Bladder Trouble					Eye Problem				
Prostate or Urinary Trouble					Tuberculosis				
Headaches					Cancer				
Stroke or Paralysis					Artery or Vein Trouble				
Convulsion					Skin Disease				
Arthritis					Hip or knee problem				
Kidney									

If you checked yes for any of the conditions on the reverse side, are any of these conditions now present?

☐ Yes ☐ No If yes, which ones? Please clarify: _____

_____

List medications or treatment you take or receive regularly and condition for which taken: _____

_____

Do you now have or have you ever had any illness or symptoms not previously referred to in this questionnaire?

☐ Yes ☐ No If yes, give details: _____

Have you ever been advised to have a surgical operation which you have not undergone? ☐ Yes ☐ No

If yes, explain: _____

Last Physical exam: Date _____ Result _____

LIST BELOW ALL HOSPITALIZATIONS: (If None, Please write 'None')

Year	Duration	Reason/Result	Hospital and Physician's Name

LIST BELOW ALL VISITS TO OR BY A DOCTOR IN THE PAST 5 YEARS (If No Visits, write 'None')

- Use additional sheets if more space is required

Date	Reason for Visit/Diagnosis	Physician's Name and Address

I have read the foregoing statements and answers and declare them to be true and complete to the best of my knowledge and belief. I agree that they shall be the basis of my acceptance for membership in the SHARE Health Plan. I realize that any misrepresentation or omission regarding the presence of pre-existing impairments or disease will result in cancellation of my coverage.

I hereby authorize and request any hospital, clinic, institution, physician or other person to furnish the SHARE Health Plan full particulars of diagnosis, treatment, medical history or any other information and conclusions about me and to accept as valid a photocopy of this authorization and my signature.

Date: _____ Signature: _____

APPLICANT — PLEASE DO NOT WRITE BELOW THIS LINE

THE GREATER MARSHFIELD

Community Health Plan

715-387-5621 **1-800-472-2363**

Administrative and Sales Office — Clinic Building

1000 North Oak Avenue — Marshfield, Wisconsin 54449

THE GREATER MARSHFIELD COMMUNITY HEALTH PLAN MEDICARE PROGRAM

The Greater Marshfield Community Health Plan (GMCHP) was developed in 1972 by the Marshfield Clinic, St. Joseph's Hospital, Blue Cross of Wisconsin and Surgical Care — Blue Shield (now known as Blue Cross Blue Shield United of Wisconsin). The goal of the Plan is to provide an alternate form of financing medical care, with an emphasis on comprehensive care. Participation in the Plan is available to all residents of the area under age 65. With over 54,000 enrollees as of December, 1979, the Plan has had a measure of success as a truly community-wide program. The only major segment of the community unable to participate has been those on Medicare. However, through a special arrangement with the federal Health Care Financing Administration (HCFA), a contract recently awarded to the Marshfield Medical Foundation makes it possible for Medicare eligible persons to enroll in the GMCHP.

The GMCHP will provide all the benefits covered by Medicare plus additional benefits including preventive care, physical exams, and home and office calls. There will be no co-pays, deductibles or the "allowed charge" limits presently experienced under Medicare. In fact, Health Plan members will have no bills to pay, except for services that are not covered, such as prescription drugs. Most members will never have to file a claim, with Medicare or GMCHP. The only cost to the participant is the monthly premium of $21.67. Participants must also continue to pay the premium for Medicare Part B medical insurance. The combination of GMCHP and Medicare will provide a complete program of medical and hospital care at a fixed monthly premium cost.

The preceding gives you a general idea of what the GMCHP Medicare Program is all about. To help you fully understand the Program, the following pages include:

If you have any questions or need any more information, we will welcome hearing from you. You can speak with a GMCHP staff member at the Marshfield Clinic about the GMCHP Medicare Program by calling 387-5621. For long distance, use this toll free number: 1-800-472-2363.

AFFILIATED WITH BLUE CROSS BLUE SHIELD UNITED OF WISCONSIN

MARSHFIELD MEDICAL FOUNDATION
MEDICARE CONTRACT

The GMCHP Medicare Program is made possible by a contract between the Marshfield Medical Foundation and the Health Care Financing Administration of the federal government. This contract will help determine if an alternate method of financing Medicare is feasible. The contract is intended to run until September 30, 1982. In the event that the program terminates on or before that date, GMCHP will, if possible, continue to be made available to Medicare participants with minimal change. If changes are necessary, enrollees will be returned to their general Medicare coverage and a Blue Cross Blue Shield United Medicare Supplement will be made available to them with no waiting periods or exclusions due to health status. **Under no circumstances will enrollees be left without coverage.**

GREATER MARSHFIELD COMMUNITY HEALTH PLAN BENEFITS
WHERE TO OBTAIN SERVICES

The GMCHP Medicare Program will provide all the covered services described on page's 2 to 4 only if obtained from the doctors and other providers affiliated with GMCHP. Health Plan members may use the services of any GMCHP Affiliate, but out-of-area coverage is limited to emergencies and referrals. If a member receives a service from a doctor, hospital, or other provider **not** affiliated with GMCHP, and the service is **not** a medical emergency or a referral from a GMCHP Affiliate, neither GMCHP nor Medicare will be liable for payment of that service. A list of GMCHP Affiliated Providers is included with this brochure.

HOSPITAL SERVICES	**BENEFITS**
Length of Stay	Unlimited number of days per admission
Room Rate	Semi-private covered. Private covered if medically necessary
Miscellaneous Charges	Covered
Outpatient Surgery	Covered
Emergency Care (Illness or Injury)	Covered
Radiation Therapy	Covered
Outpatient X-ray and Lab	Covered
Inpatient Care for Mental Conditions, Alcoholism, and Drug Abuse	Up to 70 days. Renews after a separation of 90 days between discharge and readmission
Pulmonary Tuberculosis	Maximum of 90 days. Services include inpatient care, maintenance, and outpatient dispensary services
Blood, Blood Plasma and their Administration	Covered, including a blood processing fee charged to the hospital by a blood bank or blood center
Nursing Home Care (semi-private accommodations)	Covered as long as such care is necessary for the recovery and treatment of the participant and when the request is made by a GMCHP physician
Out-of-Area Care	Emergencies and referrals worldwide for medically necessary covered services
*Prosthetic Devices (artificial limbs, etc.)	Covered, except for non-rigid appliances and supplies; experimental or research devices; and services covered by a homeowner's or similar insurance policy.

GREATER MARSHFIELD COMMUNITY HEALTH PLAN

Affiliated Providers and Hospitals

PHYSICIANS

All physicians in Clark County
All physicians in Taylor County
All physicians at the Marshfield Clinic, including those at the Greenwood Clinic, the Ladysmith, Clinic, the Mosinee Clinic, the Stanley Medical Center, and the Athens Medical Center.

JOINT AFFILIATES

All physicians affiliated with the North Central Health Protection Plan, which includes all physicians in Marathon County.

AFFILIATED HOSPITALS

St. Joseph's Hospital, Marshfield
Memorial Hospital, Neillsville
Memorial Hospital of Taylor County, Medford

AFFILIATED PHYSICIANS

Abbotsford
C. M. Ellis, D.O.

Chippewa Falls
R. D. Kennedy, M.D.

Colby
J. W. Koch, M.D.
E. D. Pfefferkorn, M.D.

Cornell
R. L. Hendricksen, M.D.

Eau Claire
G. E. Fleming, M.D.
Medical X-ray Consultants

Loyal
A. P. Hable, M.D.

Marshfield Podiatrist
K. W. Rice, D.P.M.

By Referral Only
Riverdale Marriage & Family Clinic
(LaCrosse Office Also)

Medford
V. Uhri, M.D.

Medford Clinic
—J. R. Keuer, M.D.
—M. Kanca, M.D.
—L. Kanca, M.D.
—W. W. Meyer, M.D.
—R. P. Moscoso, M.D.
—D. Oliveros, M.D.
—D. H. Shah, M.D.

Neillsville
Neillsville Clinic
—A. M. Algan, M.D.
—A. Capati, M.D.
—N. R. Capati, M.D.
—F. P. Gregorio, M.D.
—B. O. Gungor, M.D.
—N. Neelagaru, M.D.
—R. V. Reddy, M.D.
C. H. Ozturk, M.D.

Pittsville
R. D. Capling, D.O.

Rhinelander
M. Wood, M.D.

Rib Lake
S. F. Hesse, M.D.

Rice Lake
Indianhead Medical Group
—L. R. Cotts, M.D.
—M. M. Cragg, M.D.
—C. E. Eastwold, III, M.D.
—J. Henningsen, M.D.
—J. K. Hoyer, M.D.
—L. A. Kristensen, M.D.
—J. F. Maser, M.D.
—V. Narins, M.D.
—M. T. Nymo, M.D.
—L. A. Thompson, M.D.

Stanley
D. A. Sallis, M.D.
Stanley Clinic
—R. J. Matwig, M.D.

Thorp
J. Connolly, M.D.

Wausau
Radiology Associates

Withee
J. W. Johnson, M.D.

Black River Falls
Krohn Clinic

AFFILIATED DENTISTS

Abbotsford
L. E. Kallstrom, D.D.S.

Colby
N. O. Jackson, D.D.S.
M. R. Weimert, D.D.S.

Dorchester
A. W. Schief, D.D.S.

Edgar
B. N. Hurst, D.D.S.

Ladysmith
K. O. Bergsbaken, D.D.S.
A. W. B Boehmer, D.D.S.
K. D. Gerken, D.D.S.
R. L. Hafdahl, D.D.S.

Marathon
W. M. Meacham, D.D.S.
M. J. Strong, D.D.S.

Marshfield
G. C. Chronquist, D.D.S.
R. P. Coopmans, D.D.S.

AFFILIATED DENTISTS CONT'D

Marshfield (Cont'd)

Dental Associates
—W. Berry, D.D.S.
—K. Baldauf, D.D.S.
—J. J. Hagman, D.D.S.
—C. Imel, D.D.S.
—J. T. Jarosz, D.D.S.
—R. F. Jennejohn, D.D.S.
—R. J. Koller, D.D.S.
—J. J. Lang, D.D.S.
—S. Larson, D.D.S.
—T. C. Licking, D.D.S.
—J. F. Lueck, D.D.S.
—C. A. Topp, D.D.S.

R. H. Kalsched, D.D.S.
R. Kay, D.D.S.
G. P. Martin, D.DS.
T. C. Potter, D.D.S.
A. P. Schulte, D.D.S.
J. L. Smith, D.D.S.
R. L. Van der Vorste, D.D.S.

Medford

E. L. Gelhaus, D.D.S.
K. Gowey, D.D.S.
L. G. Melbinger, D.D.S.
D. Miskulin, D.D.S.

Mosinee

T. K. Brown, D.D.S.
F. G. Evans, D.D.S.
G. Knoedler, D.D.S.
J. Michna, D.D.S.

Neillsville

Associated Dentists
—R. E. Heineck, D.D.S.
—C. N. Schield, D.D.S.
—D. E. Schield, D.D.S.

Rib Lake

D. D. Powers, D.D.S.

Stanley

M. Einhorn, D.D.S.
V. C. Flaten, DD.S.

Thorp

J. R. Asbeck, D.D.S.
G. V. Brukholder, D.D.S.
J. J. Deitzler, D.D.S.
G. A. Schief, D.D.S.
B. D. Slota, D.D.S.

Wausau

T. M. Fischer, DD.S.
J. F. Peerenboom, D.D.S.

Wausau

Riverview Dental Associates
—D. A. Derwinski, D.D.S.
—J. J. Hansen, D.D.S.
—D. E. Kiger, D.D.S.
—T. J. Nick, D.D.S.
D. H. Wagner, D.D.S.

Oral Surgeons — Wausau

R. N. Gettino, D.D.S.
C. S. Hintz, D.D.S.
R. C. Shukes, D.D.S.

AFFILIATED OPTOMETRISTS

Abbotsford

R. K. Anderson, O.D.

Ladysmith

J. M. Lyons, O.D.
J. H. Runstrom, O.D.

Marshfield

K. Berg, O.D.
F. W. Fornefelt, O.D.
C. S. Taylor, O.D.

Medford

R. Arndt, O.D.
R. J. May, O.D.

Mosinee

P. N. Fleming, O.D.
R. C. Kuehl, O.D.
G. R. Leach, O.D.

Neillsville

J. W. Foster, O.D.
R. T. Harvey, O.D.
R. D. Peters, O.D.

Stanley

R. F. Goswitz, O.D.
F. C. Munns, O.D.
M. S. Torgenson, O.D.

Thorp

M. H. Melcher, O.D.
W. R. Sprague, O.D.

Wausau

R. J. Alexejun, O.D.
R. M. Goga, O.D.
D. O'Keffe, O.D.
C. W. Paepke, O.D.
M. L. Peterson, O.D.
M. J. Sikes, O.D.
R. Sikes, O.D.

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*Durable Medical Goods (Purchase or rental of wheelchairs, hospital beds, crutches, etc. Many other medically necessary items are covered. Approval is based on Medicare guidelines and must be prescribed by a GMCHP physician.)	Covered, except for deluxe equipment, unless required for the participant to operate the equipment; items not primarily medical in nature or for comfort and convenience; physicians' equipment; disposable supplies; exercise and hygienic equipment; self-help devices not primarily medical in nature; experimental and research equipment.

*Durable medical goods and prosthetic devices must be prescribed by a GMCHP physician who must also indicate the duration of its use. The decision to purchase or rent the equipment is made at the discretion of the GMCHP.

CLINIC AND PHYSICIAN SERVICES	BENEFIT
Maximum Charges	Unlimited
Surgery	Covered
Specialist Care and Consultants	Covered
Home and Office Calls	Covered
Emergency Care (Illness or Injury)	Covered
X-ray and Lab Charges at the Clinic	Covered
Radiation Therapy at the Clinic	Covered
Physical Examinations	Covered
Physical Therapy and Speech Therapy	Covered
Injection and Medication rendered in Physician's Office	Covered
Vision Care	Covered, but does not include cost of frames or lenses, except for initial contact lenses implanted following cataract surgery.
Outpatient Psychiatric Care	20 Visits. Renews after a separation of 90 days between visits or 90 days after the 20th visit.
Oral Surgery	Any service performed at the Marshfield Clinic's oral surgery department and all oral surgery procedures performed by affiliated oral surgeons.
Dental Services performed outside of the Marshfield Clinic but provided by GMCHP's affiliated dentists (see attached list)	Covered for the following items: 1. Extractions of erupted teeth. 2. Apicoectomies (surgical procedures done in lieu of root canal therapy).

	3. Any x-ray used in conjunction with the above listed procedures. 4. Emergency care associated with covered problems. 5. Endodontic, periodontic, and orthodontic therapy, dental restorations and prosthetic rehabilitation of dental injuries associated with the removal of neoplasm from the jaws; facial fractures; alveolar fractures; avulsed or partially avulsed teeth. There will be no benefits for injuries or damaged teeth, natural or otherwise, resulting from or caused by chewing of food or similar substances.
Physician's Maternity Charges	Covered
Podiatry Services	Covered
Out-of-Area Care	Emergencies or referrals worldwide for medically necessary covered services

MISCELLANEOUS SERVICES	**BENEFIT**
Professional Ambulance Service	Covered when used locally to and from a legally constituted hospital or clinic.
Orthopedic Braces (does not include braces for teeth)	Covered
Oxygen and Rental of Related Equipment	Covered
Home Care	Covered for as long as such care is necessary for the recovery and treatment of the participant and when the request is made by a GMCHP physician
Manual Manipulation of the Spine to correct a subluxation (dislocation) that can be demonstrated by X-ray	Covered if received at the Marshfield Clinic

LIMITATIONS AND EXCLUSIONS

COORDINATION OF BENEFITS — LIMITATION

Since it is not intended that you receive more benefits than the actual medical expenses incurred, the benefits payable under the GMCHP will be coordinated with those of any other group coverage you may have. This eliminates the possibility of duplicate payments.

SUBROGATION — LIMITATION

If you suffer illness or injury because of the negligence of a third party, then you transfer your right to damages to the GMCHP. This allows the GMCHP to recover payments that are the liability of someone else. Naturally, you transfer your right to damages only to the extent of the benefits payable under this contract.

COVERAGE EXCLUSIONS

No benefits are provided for:

Dental services, except as contractually provided (See "Benefits").

Hearing aids, dentures, eyeglasses, contact lenses, except for the initial contact lenses implanted following cataract surgery.

Accommodations, care, services, equipment, medications, devices or supplies furnished without charge or covered by a Workers' Compensation Act or any Employer Liability Law.

Plastic surgery for cosmetic purposes, except after an accident.

Custodial care or rest cures, care in custodial, domiciliary, and similar institutions.

Physical examinations not required for care and treatment of a participant, nor medical reports or any services for appearances at trials and hearings in litigation matters.

Services of non-participating hospitals, clinics, or physicians, except in an emergency or in case of a referral or admission authorized by a GMCHP physician.

Periodontia (except as stated in "Dental Services").

Prescription Drugs.

QUESTIONS AND ANSWERS ABOUT
THE GREATER MARSHFIELD COMMUNITY HEALTH PLAN
MEDICARE PROGRAM

We have listed below questions most frequently asked about the GMCHP Medicare Program. We believe that this information will assist you in making your decision about the GMCHP.

1. Q: What is the premium for the GMCHP Medicare Program?
   A: The premium is $21.67 per month per person. This premium is guaranteed until at least September 30, 1980.

2. Q: How often will I be billed for the premium?
   A: Premiums are billed on a quarterly (once every three months) basis for a total quarterly bill of $65.01 per person enrolled.

3. Q: When will my first premium payment be due?
   A: Your first premium payment is due when your completed application form is submitted to the GMCHP office or representative.

4. Q: What does the premium cover?
   A: $13.00 of the monthly premium covers the average amount Medicare participants will pay for Medicare deductibles and coinsurance. $8.67 covers the benefits provided by GMCHP in addition to Medicare.

5. Q: How long will this rate be in effect?
   A: The rate will be in effect at least until September 30, 1980.

6. Q: Must I continue to pay my premium for Medicare Part B, Medical Insurance?
   A: Yes. To be a member of the GMCHP, you must be entitled to Medicare Part A, Hospital Insurance, and you must continue to pay your Part B premium to Medicare. For most people, this premium is deducted automatically from the Social Security check.

7. Q: Will there be any charges to patients for services?
   A: There will be no charges for any services covered by GMCHP benefits as described on pages 2 to 4. There will be charges for services or items not covered by GMCHP, such as prescription drugs.

8. Q: Will there be any charges for office calls or home calls?
   A: No. Office calls and medically necessary home calls are paid in full by the GMCHP.

9. Q: Will I have to file claims with GMCHP or Medicare?
   A: For most services you receive from providers affiliated with GMCHP, you will never have to file claim with GMCHP or Medicare. You may receive a bill for a service from a provider not affiliated with GMCHP. You should forward the bill to GMCHP. If this service was not a medical emergency or authorized by an affiliated physician, neither GMCHP nor Medicare will be liable to pay for that service.

10. Q: Will services be covered for my current illness?
    A: Yes. There are no waiting periods or clauses for pre-existing conditions. The only limitation: you cannot join GMCHP while you are an inpatient in the hospital.

11. Q: Are prosthetic devices, glasses, drugs, dentures and hearing aids covered?
    A: Prosthetic devices and lenses after eye surgery are covered as prescribed, but dentures, hearing aids and drugs are not covered.

12. Q: Are the services of a chiropractor covered?
A: Chiropractors are not GMCHP Affiliated Providers. The equivalent services covered by Medicare are available from Affiliated Providers. So, if you do go to a chiropractor, GMCHP will not pay and Medicare will not pay.

13. Q: Will I have out-of-area coverage?
A: Yes. But only for medical emergencies and written referrals from affiliated physicians. **If you go out of the GMCHP area for services which are not emergencies or referrals, neither GMCHP nor Medicare will pay for those services. You will be liable for all charges.**

14. Q: Must a person live in the Greater Marshfield service area to be eligible for coverage?
A: A person must reside within the area encompassed by the zip codes defining the GMCHP enrollment on page 8 for at least nine (9) months of the year, or be eligible for enrollment in GMCHP through their employment.

15. Q: I am entitled to Medicare because of disability, but I am under 65. Can I join GMCHP?
A: Yes. You may join regardless of whether you have Medicare because of age, disability, or chronic kidney disease.

16. Q: I will be turning 65 soon. When may I enroll in GMCHP?
A: You can submit an application as soon as you receive your federal Medicare card.

17. Q: I am over age 65 and my spouse is under age 65. What is available to us?
A: Anyone entitled to Medicare can join the Greater Marshfield Community Health Plan. A spouse not eligible for Medicare can, if so desired, join the Greater Marshfield Community Health Plan on a single basis at the single premium rate applicable. Also, when two or more family members are not Medicare beneficiaries, the beneficiary may enroll in GMCHP through his or her family at no cost in addition to the regular GMCHP family premium rate then in effect.

18. Q: What if I decide to move to a warmer climate for 4 to 6 months of the year?
A: Eligibility requirements are such that you must reside in the service area at least nine (9) months of the year, so you would not be eligible for this program.

19. Q: What options will I have should I decide to leave the GMCHP Medicare Plan?
A: To leave the GMCHP Medicare Plan, you must submit a notice of termination to GMCHP 30 days prior to such desired date of termination. Upon that date, you will revert to your general Medicare coverage and you can transfer to a regular Blue Cross Blue Shield United of Wisconsin supplement to Medicare without waiting periods or exclusions due to health status. The rates charged for this program will be those applicable at the time of termination.

20. Q: Will I have a choice of physicians?
A: You will have an opportunity to pick a general practitioner or specialist from the affiliated providers to be your personal physician.

21. Q: May I change doctors at any time under GMCHP?
A: You pick any doctor affiliated with the Plan as your doctor. If you wish to change, there will be no need for an explanation.

22. Q: How long are medical facilities open during the course of the day?
A: Regular visits to the Marshfield Clinic and other Affiliated Physicians' offices will be provided by appointment during usual business hours. Emergency medical care is available 24 hours a day at Affiliated Hospitals.

23. Q: Will I owe GMCHP for any amounts I collect from other health insurance I carry?
A: No, unless you are enrolled through a group for your other insurance.

24. Q: I just submitted my application. When does my coverage become effective?
A. If your application is received by the 10th day of the month, your coverage will become effective on the 1st of the month two months later. For example, applications received between January 10th and February 10th will become effective on April 1st.

THE GMCHP MEDICARE PROGRAM ENROLLMENT AREA

To be eligible for the GMCHP Medicare Program you must reside in one of the following areas at least nine (9) months of each calendar year:

Clark County

Chili	54420
Curtiss	54422
Dorchester	54425
Granton	54436
Greenwood	54437
Humbird	54746
Loyal	54446
Neillsville	54456
Owen	54460
Stanley	54768
Thorp	54771
Willard	54493
Withee	54498

Eau Claire County

Fairchild	54741

Marathon County

Abbotsford	54405
Athens	54411
Colby	54421
Edgar	54426
Fenwood	54431
Hamburg	54438
Marathon	54448
Milan	54453
Mosinee	54455
Spencer	54479
Stratford	54484
Unity	54488

Chippewa County

Stanley	54768
Boyd	54726

Taylor County

Gilman	54433
Hannibal	54439
Lublin	54447
Medford	54451
Rib Lake	54470
Stetsonville	54480
Westboro	54490

Wood County

Arpin	54410
Auburndale	54412
Blenker	54415
Hewitt	54441
Marshfield	54449
Milladore	54454
Pittsville	54466
Vesper	54489

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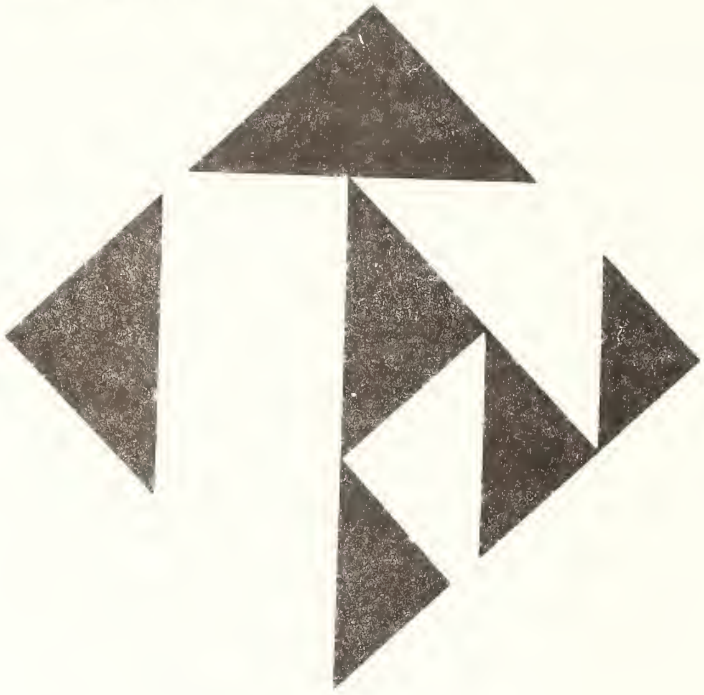
Fallon Community
Health Plan



SENIOR PLAN

A Choice for Persons Covered by Medicare

In Cooperation With

Blue Cross
of Massachusetts

630 Plantation Street, Worcester, Massachusetts 01605

We are pleased to announce the SENIOR PLAN, a new concept in health care for persons covered by Medicare. For a long time we have been aware of your special problems; you need more health care services; your income may be fixed, yet costs continue to rise; forms are confusing; many services are only partially covered or are not covered at all.

The SENIOR PLAN has been designed, in cooperation with Medicare, to solve these problems. The SENIOR PLAN provides more benefits, reduces your costs, and eliminates confusing forms.

You may now choose to receive your health care through the SENIOR PLAN.

We hope you will read this booklet carefully and then consider joining the SENIOR PLAN.

Arthur G. Corty
President
Blue Cross of Massachusetts

John Meyers, M D
President, Follon Clinic

John P. O'Connell
Executive Director
Follon Community Health Plan

Table of Contents

Your Choice

- This booklet has been designed to help you decide if the SENIOR PLAN is best for you. After reading the booklet and having us answer any questions you may have, you should be able to decide to:
  - Choose the SENIOR PLAN; or
  - Retain your present coverage

Quarterly Charges for SENIOR PLAN Membership

- $22.50 paid quarterly
  (charges with company retiree groups may vary)

The Choice is Completely Yours. Read On!!

Services Covered by the SENIOR PLAN

All Services Listed Are Covered Only When Provided or Arranged by Fallon Clinic Professionals

Services	Your Cost
At the Fallon Clinics or on referral to another provider:	
• Office visits including all medical and surgical care	No Charge
• Periodic physical examinations	No Charge
• Consultations and care by specialists	No Charge
• X-ray and laboratory services	No Charge
• Allergy tests and injections	No Charge
• Immunizations and injections	No Charge
• Radiation therapy	No Charge
• Hearing tests	No Charge
• Physical and respiratory therapy	No Charge
• Hemodialysis services	No Charge
• Casts and dressings	No Charge
• Health education and medical/ social services	No Charge
At the Fallon Clinic:	
• Eye exam for glasses—one each 12 month period	No Charge
• Eyeglasses—one pair each 12 month period	No Charge
At the Fallon Clinic Pharmacy:	
• Drugs requiring a physician's prescription	$1.00 for each prescription or refill

Services	Your Cost
In the Hospital:	
• Unlimited days for room and board in semiprivate accommodations	No Charge
• Physician and surgeon services including operations and specialists' consultations	No Charge
• Intensive Care services	No Charge
• Hospital "special services"—including items such as operating room, anesthesia, recovery room, drugs, x-ray and laboratory services	No Charge
• Physical and respiratory therapy	No Charge
• Hemodialysis services	No Charge
• Radiation therapy	No Charge
• Prescribed private duty nursing	No Charge
In a Skilled Nursing Facility:	
• Up to 100 days in a benefit period* for semiprivate room	No Charge
Mental Health Services:	
• At the Fallon Clinic: Up to 20 visits in a calendar year, or $500 worth of care each calendar year, whichever is a greater benefit	No Charge
• In a General Hospital: Room and board for an unlimited number of days, special services and professional services	No Charge
• In a Mental Hospital: Room and board, all institutional and professional services up to a combined maximum of 90 days in a benefit period*	No Charge

Services	Your Cost
In Your Home:	
• Services of a Home Health Care Agency	No Charge
Other Health Services:	
• Ambulance services	No Charge
• Durable medical equipment and prosthetic devices	No Charge
Emergency Services:	
• In the area Prior authorization from the FCHP is required, except for severe or life-threatening emergencies. In these cases, members are expected to call the FCHP as soon as possible after receiving care	No Charge
• Out of the area	No Charge

*BENEFIT PERIOD means the period of time which starts when you are admitted to a hospital or skilled nursing facility. It ends once you are out of a hospital or skilled nursing facility for 60 days in a row.

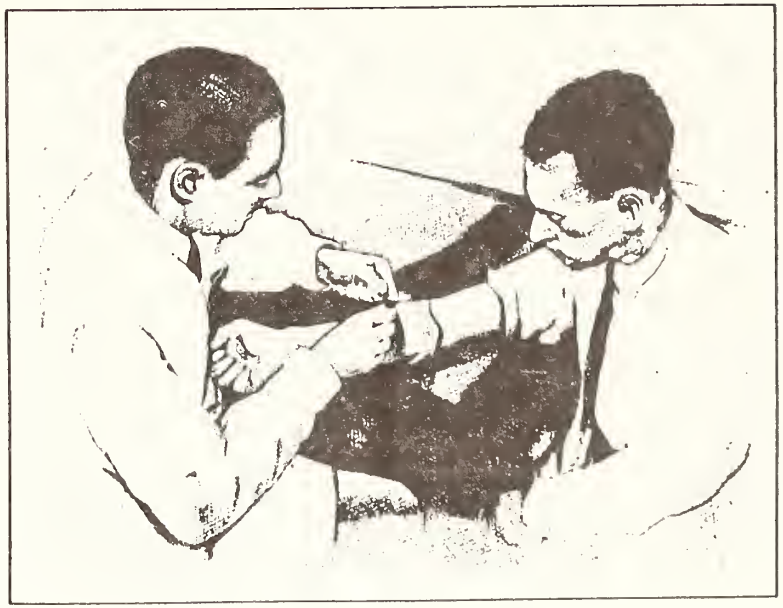
This booklet is a summary of your SENIOR PLAN benefits. The Fallon Community Health Plan SENIOR PLAN Evidence of Coverage defines the terms and conditions of the Plan in greater detail. Should any questions arise concerning your benefits, the SENIOR PLAN Evidence of Coverage will govern.

What is the Fallon Community Health Plan?

It is a Health Maintenance Organization (HMO). It provides personal routine care as well as full coverage for major illness through the facilities of the Fallon Clinic. The Plan helps protect your health by stressing early disease detection, prevention and prompt treatment.

The Fallon Community Health Plan is State Licensed and Federally Qualified. Since 1977 it has been offered, as an option, to employees of over 500 area companies. Over 30,000 persons are enrolled, including almost 4,000 SENIOR PLAN members.

The HMO concept is rapidly growing throughout the United States. Nearly nine million people have joined health maintenance organizations.



What is the SENIOR PLAN?

It is an HMO for persons who have Medicare. The SENIOR PLAN combines Medicare coverage and HMO benefits into one program. It was developed under a contract with the U.S. Government (Medicare).

The SENIOR PLAN is a special pilot program that will continue until December 31, 1982. We hope to continue the SENIOR PLAN beyond that date. If it should be discontinued for any reason, you may transfer to a Blue Cross and Blue Shield MEDEX® membership without a lapse in coverage or penalties of any kind.

The SENIOR PLAN will only pay for health services that you receive from the Fallon Clinic or from physicians and other health care providers that have been authorized by the Fallon Clinic, except in cases of emergency or urgently needed services. If you receive health care services, other than an emergency service, that is not authorized by the Fallon Clinic, neither the SENIOR PLAN nor Medicare will pay for that service and you will be liable for full payment.

Am I Eligible?

You are eligible for the SENIOR PLAN if you are enrolled in Medicare Parts A (Hospital Insurance) and B (Medical Insurance) and you live within Worcester County. If you enroll in the SENIOR PLAN, you MUST continue your Medicare coverage.

What is the Fallon Clinic?

The Fallon Clinic is a multi-service health care center that has served the Worcester area since 1929. Over 50 staff physicians share a modern, well-equipped facility with services such as x-ray, laboratory, EKG, EKG stress testing, vision and hearing testing, a minor surgical suite, an optical dispensary and a pharmacy.

Special services such as nutrition and alcohol counseling are provided as well as a variety of patient education classes.

The Fallon Clinic is located at 630 Plantation Street, Worcester, and at 95 East Main Street, Westborough. Patients may use either location. Public transportation and ample parking are available. Additional facilities are proposed in Auburn and should be available soon.

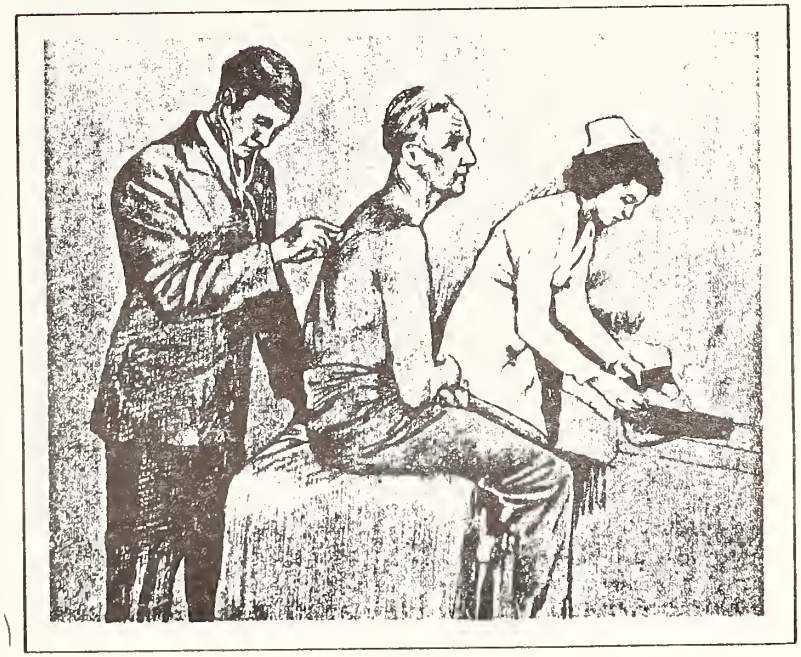
While the Clinic serves Fallon Community Health Plan and SENIOR PLAN members, it will also continue to welcome all patients from the community.

Preventive Services and Health Education

Finding and treating illnesses early is common sense. Preventing illness through regular health care, physical examinations and immunizations, such as flu shots, makes even more sense.

The SENIOR PLAN stresses preventive medicine by covering such items as physical examinations and routine eye examinations. We stress early care by allowing you to see a doctor as often as necessary at no charge to you.

Finally, you will find a wide variety of health education services available to you. On staff we have a registered dietician, an alcohol counselor and other professionals. We also hold monthly educational meetings, stressing a different subject each month.



What Are the Advantages of the SENIOR PLAN?

- **Convenience**
  Care is pravided thraugh the facilities af the Fallon Clinic, a well-staffed and equipped multi-service health care center. Members find that most needed services are available in the persanal comfort af the Clinic.

- **No Claims to Submit**
  There are no deductibles ar claim forms under the SENIOR PLAN. All benefits are cavered in full except for the $1.00 charge for each prescriptian ar refill.

- **Increased Benefits**
  The SENIOR PLAN cavers traditional benefits such as unlimited haspitalizatian paid in full.
  The SENIOR PLAN alsa cavers special benefits that are not cavered by traditional insurance such as:
  - Routine Care in a Dactar's Office at no charge
  - Eye Examinatians and Eyeglasses at na charge
  - Prescription Medicatian at $1.00 far each prescriptian ar refill
  - Physical Examinatians and Immunizatians

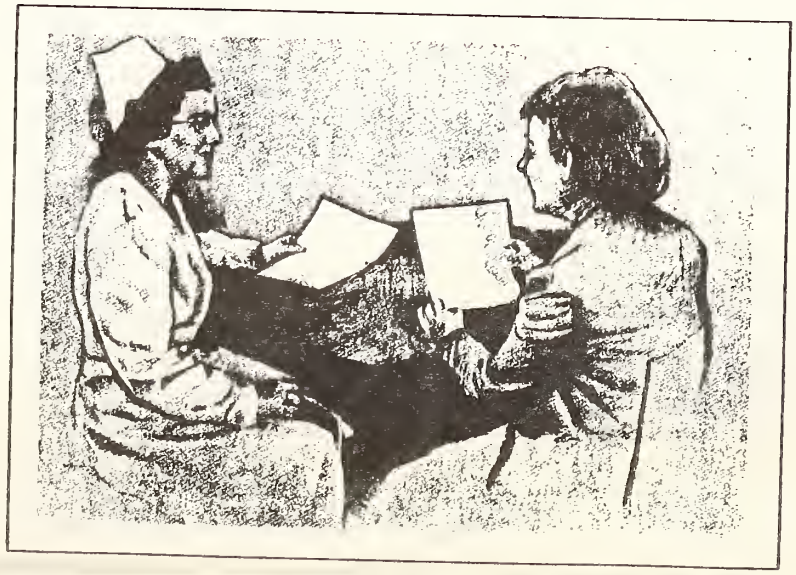
- **Cost Savings**
  The Federal Gavernment allaws us ta transfer same of their savings ta you in the farm af increased benefits and low quarterly premiums. The savings are the result af the mare efficient HMO appraach ta health care.

- **A Personal Physician**
  You have a chaice of persanal physicians fram the Fallan Clinic staff. Members are encauraged ta see their physician as often as necessary. All visits are by appaintment. Care is available immediately if urgently required.

- **Freedom From Worry**
  With virtually complete caverage and a reasanable quarterly premium, yau shauld never warry abaut the cast af medical care as a SENIOR PLAN member. Yau are encouraged ta seek health care regularly withaut warrying about the cast.

Are Any Services Not Covered?

- Any service in or aut af the hospital not provided or arranged by a FCHP physician, except in covered emergencies.
- Casmetic surgery.
- Personal comfort items, such as telephone, radio or televisian or housekeeping services.
- Dental care and dentures.
- Hearing aids, and hearing aid examinations.
- Custodial care (such as care in a nursing hame that is mainly ta help with bathing, eating, dressing, getting in and aut of bed, etc.).
- Insulin and syringes.



Where Do I Receive Services?

Physician Services

All doctar's services are provided at the Fallan Clinic. If you require the care of a specialist not on the Fallan staff, your Fallon doctar will refer yau ta the appropriate specialist and you will be **covered in full.**

Hospital

Hospital services are provided at St. Vincent Hospital, the University of Massachusetts Medical Center, and Fairlawn Hospital. Mast patients are treated at St. Vincent Hospital. Again, if you require specialty care not available at our participating hospitals, you will be referred ta an appropriate hospital and be **covered in full.**

Eye Care

All eye care services, including eyeglasses, are provided at the Fallon Clinic. The SENIOR PLAN will cover ane pair of basic first quality lens and frames, **at no charge**, each 12 month period.

Pharmacy

Yau may purchase prescriptian drugs at the Fallon Clinic Pharmacy for $1.00 for each prescription or refill.

Out Of The Area

Yau are covered for all emergency care when traveling out of the area. Your SENIOR PLAN identificatian card instructs hospitals and doctors to submit all bills to Blue Cross and the SENIOR PLAN, respectively.

Will I Have My Own Personal Physician?

A close patient/doctor relationship is important. As a member of the SENIOR PLAN, you choose a personal physician from the doctors at the Fallon Clinic. If you already have a physician at the Fallon Clinic, you are encouraged to continue to see him.

Your personal physician supervises your total care. You may visit by appointment or call for advice whenever necessary. If your doctor is temporarily unavailable, care is provided by other members of the medical group. You may change physicians on the staff at any time to ensure you are comfortable and satisfied.

Making Appointments

All visits to the Fallon Clinic are made by appointment. Regular appointments are made by calling the appointment desk Monday through Friday from 8:00 a.m. to 5:00 p.m. at:

Worcester Fallon Clinic (617) 852-0600
Westboro Fallon Clinic (617) 366-8836

When you call for an appointment, identify yourself as a SENIOR PLAN member. Be sure to keep your I.D. card handy when you call, as the information on it will be helpful to the appointment secretary.

If you must cancel an appointment, please do so at least 24 hours in advance.

Urgent Problems During Regular Appointment Hours

If you have an urgent problem, such as a sore throat or a small laceration, during regular Clinic hours, you will normally be seen right at the Clinic. Call the Fallon Clinic and tell the receptionist you have an urgent problem. If your own physician is not available, you will be seen by another member of the staff.

Emergency Care In the Area

Severe and Life-Threatening Emergencies

Any time a member's life is endangered—shock, unconsciousness, difficulty in breathing, symptoms of a heart attack, severe bleeding—care should be received at the nearest facility. You will be covered in full. Please notify the Fallon Clinic as soon as possible so that your own doctor may arrange for all follow-up care.

Non-Severe or Non-Life-Threatening Emergencies

SENIOR PLAN members must always call the Fallon Clinic, first, **(617) 852-0600** for instructions in non-severe emergencies. Doctors are on call 24 hours a day, every day of the year. When you call:

1. state that you are a SENIOR PLAN member;
2. the nature of your emergency; and,
3. the name of your doctor

Your doctor or the on-call physician will arrange for needed emergency care. If necessary, the doctor will meet you in the emergency room or arrange for your treatment.

YOU WILL NOT BE COVERED FOR NON-SEVERE EMERGENCIES UNLESS YOU CALL THE FALLON CLINIC PRIOR TO SEEKING CARE.

Emergency Care Out of the Area

You are covered in full for emergencies and urgently needed care while traveling out of the area. Please notify the SENIOR PLAN within a reasonable amount of time if you have received care out of the area. Your SENIOR PLAN identification card instructs doctors and hospitals out of the area to send all bills to either Blue Cross of Massachusetts or the SENIOR PLAN. You are covered in full.

Is the SENIOR PLAN Right for You?

Careful consideration should be given to the SENIOR PLAN before you select it. The SENIOR PLAN has many advantages, but it is not for everyone. If you have had a long, close and comfortable relationship with a physician in the community, who is not at the Fallon Clinic, you may not wish to join. However, the SENIOR PLAN may be right for you if your out-of-pocket expenses after Medicare payments are getting out of hand; if you are having trouble finding a personal physician; or if you are overwhelmed by claim forms and statements and if you find it more convenient to receive all your care at one location.

Enrollment Questions

If you have any questions on how to enroll or questions about the SENIOR PLAN, you may call or stop in:

The SENIOR PLAN at 852-4111
or
Blue Cross and Blue Shield at 791-0961 (Worcester)

Open Enrollment

Every year there will be an open enrollment period for the SENIOR PLAN. You may join the SENIOR PLAN or change to Blue Cross and Blue Shield MEDEX® coverage at that time—without penalties. You may not join the SENIOR PLAN or change to Blue Cross and Blue Shield MEDEX® coverage at other times.

Special Enrollment Periods

When you become 65, you may enroll in the SENIOR PLAN. if you move out of the area, you may change to Blue Cross and Blue Shield MEDEX® coverage. Please contact the SENIOR PLAN or Blue Cross and Blue Shield in these cases.

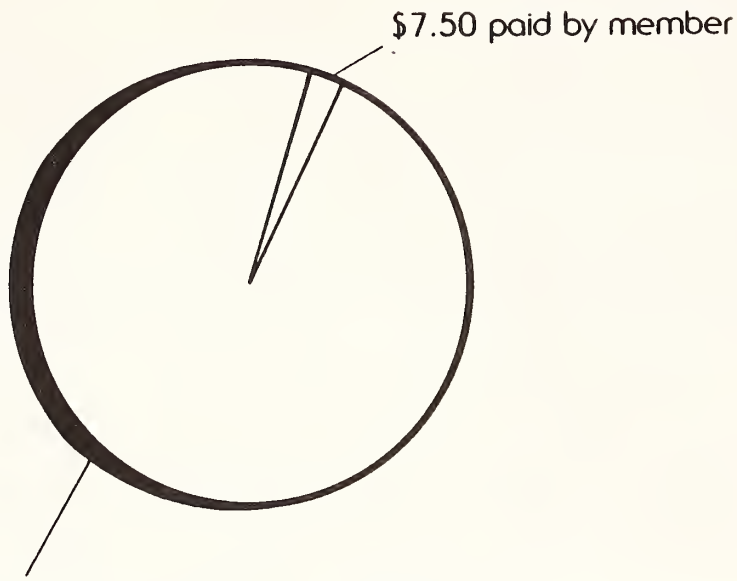
You may cancel the SENIOR PLAN at any time by giving us 60 days notice and return to Medicare but not MEDEX® MEDEX® may only be joined at the next open enrollment period.

1981 enrollment in the SENIOR PLAN is limited to the first 1700 applicants. Applications will be accepted on a first-come, first-served basis. Additional applications will be placed on a waiting list.

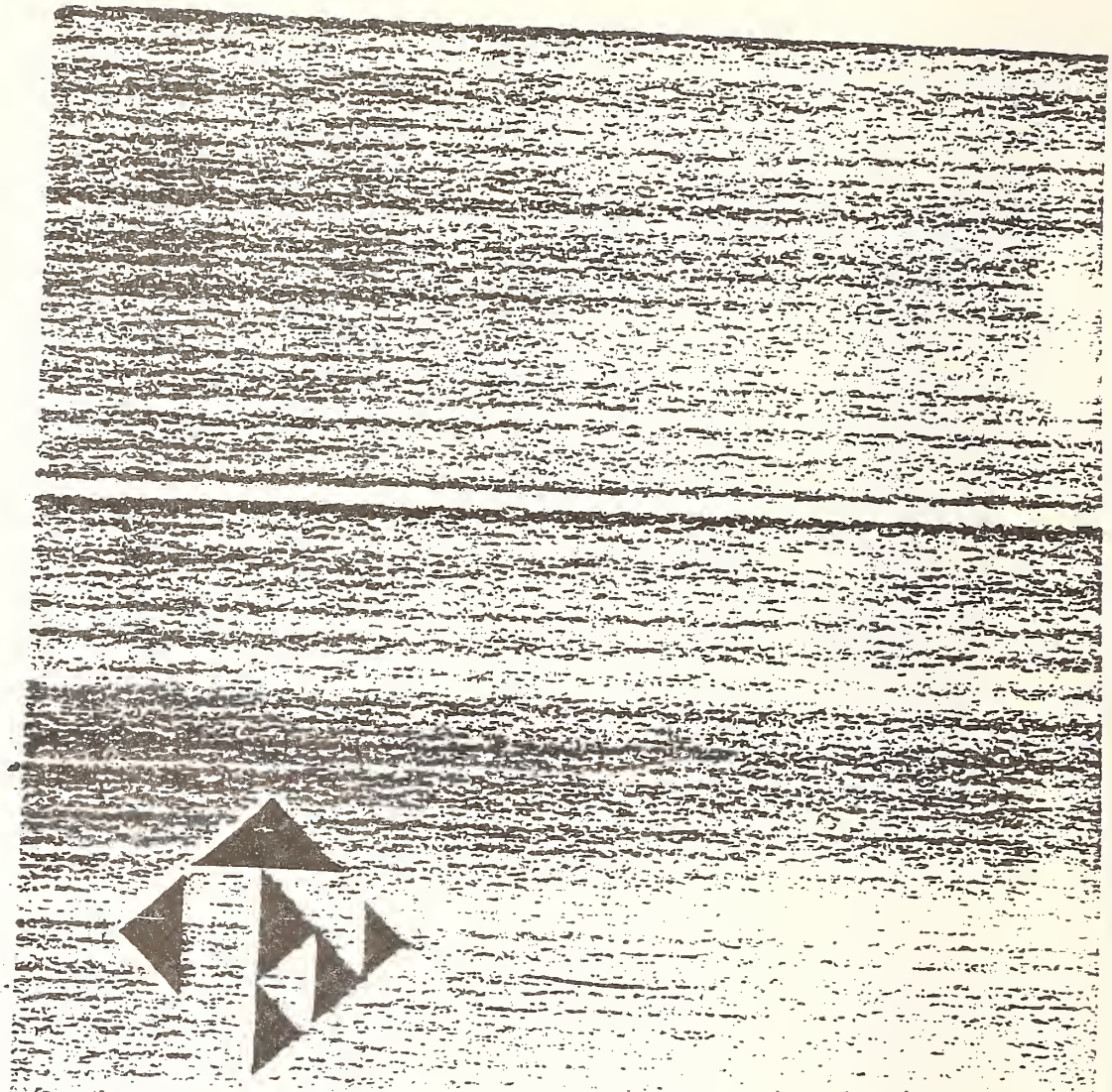
SENIOR PLAN Funding

The SENIOR PLAN provides all Medicare benefits. It also covers special benefits, valued at $39.23 a month, not available through Medicare. You pay only $7.50 per month (payable quarterly) for SENIOR PLAN membership. The SENIOR PLAN pays for all Medicare benefits and the special benefits with funds provided by the Health Care Financing Administration (Medicare) from "Medicare Trust Funds."

SENIOR PLAN— Total Monthly Cost



Remainder paid by SENIOR PLAN with funds provided by the Health Care Financing Administration (Medicare). Included are costs for special new benefits and Medicare covered services.



Fallon Community Health Plan
630 Plantation Street
Worcester, MA 01605
Tel. (617) 852-0600

Senior Plan Questions
Tel. (617) 852-4111

In Cooperation With

Blue Cross
of Massachusetts

370 Main Street
Worcester, MA 01608
791-0961

Please Call
The Fallon Clinic
For All Medical
Appointments
Tel. (617) 852-0600

APPENDIX F

SAMPLE APPLICATIONS

HC HEALTH CENTRAL

A SUBSIDIARY OF
BLUE CROSS AND BLUE SHIELD OF MICHIGAN

MEDICARE ENROLLMENT REGISTRATION FORM

CARD MUST BE DATED AND SIGNED **(DO NOT WRITE IN SHADED AREAS.)**

APPLICANT'S LAST NAME | FIRST NAME | M.I. | EFFECTIVE DATE

SOCIAL SECURITY NUMBER | SEX ☐ MALE ☐ FEMALE | DATE OF BIRTH MO. DAY YEAR | MEMBER NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE | HOME PHONE NO.

HEALTH INSURANCE CLAIM NUMBER FROM YOUR MEDICARE I.D. CARD.

DOES YOUR CURRENT/FORMER EMPLOYER PAY ANY PORTION OF YOUR MEDICARE PREMIUM? ☐ YES ☐ NO | WORK PHONE NO.

EMPLOYER NAME: _____

WERE YOU EVER A MEMBER OR HAVE YOU EVER BEEN TREATED BY HEALTH CENTRAL? ☐ YES ☐ NO

DO YOU RECEIVE MEDICAID? ☐ YES ☐ NO

MEDICAID NUMBER: _____

DO YOU OR YOUR SPOUSE HAVE ANY OTHER HEALTH INSURANCE? ☐ YES ☐ NO

NAME OF SPOUSE _____

ES, PLEASE STATE NAME OF COMPANY, ADDRESS AND POLICY NUMBER:

COMPANY NAME _____ POLICY NUMBER _____

ADDRESS _____

I HEREBY AUTHORIZE THE SOCIAL SECURITY ADMINISTRATION TO FURNISH HEALTH CENTRAL, INC., AFFIRMING MY ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS (PART A) AND ENROLLMENT FOR SUPPLEMENTARY MEDICAL INSURANCE BENEFITS (PART B) UNDER TITLE XVIII OF THE SOCIAL SECURITY ACT.

I HEREBY AUTHORIZE HEALTH CENTRAL, INC. TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION ANY MEDICAL OR OTHER INFORMATION REQUESTED WITH RESPECT TO ENTITLEMENT TO BENEFITS UNDER THE MEDICARE LAW.

I UNDERSTAND THAT BENEFITS I WILL BE ELIGIBLE FOR ARE DESCRIBED IN HEALTH CENTRAL ENROLLMENT MATERIALS FOR MEDICARE RECIPIENTS.

SIGNATURE _____ DATE _____

3103

HEALTH CENTRAL
A SUBSIDIARY OF
BLUE CROSS AND BLUE SHIELD OF MICHIGAN
2316 S. CEDAR – LANSING, MICHIGAN 48910
TELEPHONE: (517) 374-6600

№ 22369

Share Health Plan SeniorCare **ENROLLMENT INFORMATION**

A ENROLLEE DATA — PLEASE PRINT

FIRST NAME MIDDLE INT. LAST NAME

HOME STREET ADDRESS

CITY STATE MN ZIP

HOME PHONE WORK PHONE SOCIAL SECURITY NUMBER

BIRTH DATE SEX ____ Female ____ Male

MARITAL STATUS CODE ____ 1. NEVER MARRIED 2. MARRIED 3. WIDOWED 4. DIVORCED 5. LEGALLY SEPARATED

SHARE USE ONLY

EFFECTIVE DATE

PLN

GRP COV 1 LOC

E

B FILL IN BLANKS EXACTLY AS SHOWN ON YOUR MEDICARE CARD

PLEASE INDICATE WHICH COVERAGE YOU WOULD LIKE*

HIGH OPTION ☐

BASIC ☐

*ALL SERVICES MUST BE RECEIVED AT SHARE UNLESS REFERRED BY SHARE PHYSICIAN.

Health Insurance

SOCIAL SECURITY ACT

Name of Beneficiary (Your name)

Claim Number Sex

Is Entitled To: Effective Date

Hospital Insurance

Medical Insurance

I HEREBY AUTHORIZE the Health Care Financing Administration to furnish information to SHARE Health Plan affirming my entitlement to Hospital Insurance Benefits (Part A) and enrollment for Supplementary Medical Insurance Benefits (Part B) under Title XVIII of the Social Security Act and to furnish the plan information as to Part A and Part B benefits recorded, including those based on services not furnished by or through the plan, and should my enrollment be terminated, the effective month of such termination, for its use in connection with the operation of this plan.

I ALSO AUTHORIZE the SHARE Health Plan or any other holder of medical or other information about me to release to the Health Care Financing Administration or intermediaries or carriers any information needed to administer Title XVIII of the Social Security Act.

(Signature) _____

(Date) _____

C EMERGENCY CONTACT DATA (Name of nearest relative not living with you)

First Name MI Last Name Area Code Phone

Street Address City State (MN=Minn) Zip

D CLINIC CHOICE (SELECT ONE)

☐ ST. PAUL MEDICAL CENTER
555 SIMPSON ST. ST. PAUL 55104

☐ STADIUM SQUARE MEDICAL CENTER
7920 CEDAR AVE. SO., BLOOMINGTON 55420

☐ BROOKLYN PARK MEDICAL CENTER
5805 74th AVE. NO. BROOKLYN PARK 55443

☐ COLUMBIA PARK CLINIC
3620 CENTRAL AVE. N.E. MINNEAPOLIS 55418

Welcome to Share! (X) _____ Today's Date

Signature

WHITE & YELLOW—RETURN TO SHARE PINK—GROUP OR MEMBER

APPENDIX G

FALLON CASE CONFERENCE COMMITTEE SAMPLE FORMS

FALLON UTILIZATION FORM

PATIENT NAME (LAST, FIRST) [redacted]	DATE OF BIRTH 6/14/29	SEX M	HOSPITAL SVH	ADMISSION DATE 4/10/83	TIME 8:44 pm	DISCHARGE DATE
ADDRESS [redacted]	TELEPHONE [redacted]			ADMITTING PHYSICIAN Dr. Pezzella.		
SSN [redacted]	TELEPHONE			PRIMARY CARE PHYSICIAN		
ADDRESS	LIVING ARRANGEMENT			REFERRING PHYSICIAN		
PRIMARY ADMISSION Dx: R/O MI.	SECONDARY Dx: Killip I non Q-Wave MI.			DISCHARGE Dx:		

ELECTIVE ☐ EMERGENCY: ADMITTED THROUGH E.R. ☒ ADMITTED THROUGH F.C. ☐ ADMITTED DIRECTLY ☐ W/C ☐ MVA ☐

PRE ADMISSION REVIEW

PRE-ADMISSION LAB	DATES	SPECIAL PROCEDURES	DATES
PROCEDURES SCHEDULED	**DATES**	**CONSULTATION SCHEDULED**	**DATES**

A.M. ADMISSION YES ☐ NO ☐ (IF NO, SPECIFY) Records.

REFERRED YES ☐ NO ☐

PRE-HOSPITAL INFORMATION: Restrictive Lung Disease: MI 1980; ETT FC 1999., TOS; 1 ST Rib resection; Duod. ulcer - on Tagamet

PRE ADMISSION COMPLETE YES ☐ NO ☐ (IF NO, SPECIFY)

HEALTH CARE COORDINATION REVIEW

PAST HISTORY AND CURRENT COMPLAINT: Sharp Cp. radiating between shoulders & (L) hand numbness + pain in (L) arm.

LAB DATA

PROCEDURES	PHYSICIAN	DATE

OBSERVATION, GENERAL REMARKS AND DISCHARGE PLANNING: 4/14-Trans. to floor care - MI +. 4/15 - Cardiac Rehab level 4. 4/18 - Cardiac Rehab level 8/9; A fib. BP. 90/64 - Lungs clear, No C/O. MEET Wednesday.

INITIAL REVIEW

REVIEW COMMENTS

COMMITTEE COMMENTS

PHYSICIAN COMMENTS (RETURN TO COMMITTEE)

FALLON UTILIZATION FORM

(74)

FALLON CLINIC NO.	HOSPITAL MED. NO.	R.M. NO.
	11-57-64	3024

PATIENT NAME (LAST, FIRST)	DATE OF BIRTH	SEX	HOSPITAL	ADMISSION DATE	TIME	DISCHARGE DATE
[redacted]	8/21/06	m	SVH	4/11/83	4:31 pm	

ADDRESS	TELEPHONE	ADMITTING PHYSICIAN
[redacted]	NP	Dr. Beam.
	TELEPHONE [redacted]	PRIMARY CARE PHYSICIAN
	LIVING ARRANGEMENT	REFERRING PHYSICIAN

PRIMARY ADMISSION Dx	SECONDARY Dx	DISCHARGE Dx
Left lung mass. tumor		

ELECTIVE ☐ EMERGENCY: ADMITTED THROUGH E.R. ☐ ADMITTED THROUGH F.C. ☐ ADMITTED DIRECTLY ☐ W/C ☐ MVA ☐

PRE-ADMISSION REVIEW

PRE-ADMISSION LAB	DATES	SPECIAL PROCEDURES	DATES

PROCEDURES SCHEDULED	DATES	CONSULTATION SCHEDULED	DATES
		Dr Phaneuf	4/15

A.M. ADMISSION YES ☐ NO ☐ (IF NO, SPECIFY) REFERRED YES ☐ NO ☐

PRE-HOSPITAL INFORMATION PMH-Recent Compression fx T5.

PRE ADMISSION COMPLETE YES ☐ NO ☐ (IF NO, SPECIFY)

CONCURRENT REVIEW

PAST HISTORY AND CURRENT COMPLAINT 3 mos. h/o back pain, pleuritic chest pain, blood tinged productive cough, 40 lb. wt. loss, anorexia, SOB on exertion + @ rest. CXR → lingular infiltrate which did not clear c Antibiotics. Pt. adm. for eval + for R/O Malignancy.

LAB DATA

PROCEDURES

PROCEDURES	PHYSICIAN	DATE

OBSERVATION, GENERAL REMARKS AND DISCHARGE PLANNING 4/11- Consult to Dr. Padwardhan. D_2@21 per NS Sputum for C+S + Cytology ABG's drawn. 4/12- Bronchoscopy today ? Bone Scan today. ANSS.
4/13 fiberoptic bronchoscopy by Dr Sawyer - undoubtedly ca
cons. radiation tx
4/15. path → mod. well diff adeno ca. c/o back pain + inab.

INITIAL REVIEW

REVIEW COMMENTS to void ↓ breath sound LLL, cons. for P.H mult rec. iad. Dr Phaneuf inserted Foley

COMMITTEE COMMENTS

PHYSICIAN COMMENTS (RETURN TO COMMITTEE)

FALLON UTILIZATION FORM

(77)

FALLON CLINIC NO.	HOSPITAL MED. NO.	I.M. NO.
	34-11-00	1605

PATIENT NAME (LAST, FIRST)	DATE OF BIRTH	SEX	HOSPITAL	ADMISSION DATE	TIME	DISCHARGE DATE
[redacted]	4/10/05	M	SVH	4/13/83	6:05 pm	

ADDRESS	ADMITTING PHYSICIAN
[redacted]	Dr. Pezzella
[redacted]	PRIMARY CARE PHYSICIAN
[redacted]	REFERRING PHYSICIAN

PRINCIPAL DX	SECONDARY DX	DISCHARGE DX
V-Tach		

ELECTIVE ☐ EMERGENCY: ADMITTED THROUGH E.R. ☒ ADMITTED THROUGH F.C. ☐ ADMITTED DIRECTLY ☐ W/C ☐ MVA ☐

PRE-ADMISSION REVIEW

PRE-ADMISSION LAB	DATES	SPECIAL PROCEDURES	DATES
PROCEDURES SCHEDULED	**DATES**	**CONSULTATION SCHEDULED**	**DATES**

A.M. ADMISSION YES ☐ NO ☐ (IF NO, SPECIFY) REFERRED YES ☐ NO ☐

PRE-HOSPITAL INFORMATION PMH - Tachycardia; D.M.

PRE ADMISSION COMPLETE YES ☐ NO ☐ (IF NO, SPECIFY)

HEALTH CARE COORDINATOR REVIEW

PAST HISTORY AND CURRENT COMPLAINT 3-4 days gastroenteritis; ↓ ↑ weakness. In E.R. → V-Tach.

LAB DATA

PROCEDURES	PHYSICIAN	DATE

OBSERVATION, GENERAL REMARKS AND DISCHARGE PLANNING: 4/13 - Trans - venous atrial pacemaker placement. (to eval. origin tachyarrythmias). → Indicated A-V disassociation c V-Tach. On Telemetry. 4/14 - Inderal + Quinidine. Bedrest c BRP. EKG. T Max 100. Still in SVT on Telemetry. 4/15 - Quinidine level still in low therapeutic range. → Δ to Quinaglute. 4/18 - Quinadine level ordered. Telemetry still showing SVT + some SR. c occasional PVCs

INITIAL REVIEW

REVIEW COMMENTS

COMMITTEE COMMENTS

PHYSICIAN COMMENTS (RETURN TO COMMITTEE)

APPENDIX H

PRE-HOSPITALIZATION DISCHARGE PLANNING STUDY (KAISER)

KAISER FOUNDATION HOSPITALS

BESS KAISER HOSPITAL
5055 NORTH GREELEY AVENUE, PORTLAND, OREGON 97217
TELEPHONES • PORTLAND: (503) 285-9321 • VANCOUVER: (206) 694-8446

September 30, 1982

William Clark, M.D.
Chairman, Quality Assurance & Evaluation Committee
Multnomah Foundation for Medical Care
2164 S.W. Park Place
Portland, Oregon 97205

Dear Sir:

Enclosed is our Pre-Hospitalization Discharge Planning Study. The results of that study were not as conclusive as we had hoped, but it has shed some light on ways to improve contacting patients, even with the decrease in Social Work staffing.

The request for delay of submission, that you approved, enabled us to use the same time frame for comparison. Further complicating prompt submission was the change of Quality Assurance Coordinators earlier this year without benefit of overlapping time.

Thank you for your patience, and if we can be of any further assistance, please feel free to contact us.

Sincerely,

Patti Lawler

Patti Lawler, R.N.
Quality Assurance Coordinator

Celia McKinney

Celia McKinney, M.S.W.
Director of Social Work Department

PL/jk
cc: Roy Howard
Terry Carr

BESS KAISER MEDICAL CENTER

PRE-HOSPITALIZATION DISCHARGE PLANNING

STUDY BACKGROUND: A pre-hospital discharge planning program was implemented for patients with total hip replacement in March 1981. A referral is made to the hospital Social Service Department by the orthopedist before a patient is admitted for planned surgery. The Social Worker contacts the patient and makes preliminary discharge planning arrangements which may include chosing a SNF. The rationale for this program was based on the following:

a. Patients can participate more in their own care if approached before the painful experience of surgery in the hospital. Psychologists have theorized and in some instances substantiated their theories that patients who have control over their own destiny, (e.g.placements). and who are aware of expected outcome of surgery, reported less pain and might recover faster.

b. One unique feature of the discharge planning program allows the patient to visit and to chose a SNF rather than depending on friends, relatives or the advice of the Social Worker. In addition to satisfying the psychological factor, as stated in #1, this feature allows for practical placement planning. The Social Worker can negotiate to have a bed held at a SNF, which the patient has chosen, if a discharge date can be predicted. Further, the SNF is able to do a pre-operative assessment of the patient so that they may be able to set more realistic goals for the patient rather than meeting the patient for the first time during the post-operative recovery phase.

STUDY DESIGN: We realize that the theoretical basis for this program is a good one, although a very difficult one to prove. We opted to use the length of stay as an objective measurement of the effectiveness of the program.

Because of Social Work staffing decreases in 1982, not all patients referred for pre-admission discharge planning were contacted prior to hospitalization. We therefore decided to compare the two hip replacement groups; those contacted before hospitalization and those where no contact was made prior to hospitalization.

Appendix D
(Continued)

STUDY PERIOD: January 1, 1981 through July 31, 1981 vs.
January 1, 1982 through July 31, 1982

FINDINGS: Total Hip (81.51) with Pre-Discharge Planning - 1981

Total # Patients	=	12
Total # Patient Days	=	149
ALOS		12.4

Total Hip (81.51) without Pre-Discharge Planning -1981

Total # Patients	=	13
Total # Patient Days	=	155
ALOS		11.9

Total Hip (81.51) with Pre-Discharge Planning - 1982

Total # Patients	=	7
Total # Patient Days	=	78
ALOS	=	11.1

Total Hip (81.51) without Pre-Discharge Planning - 1982

Total # Patients	=	10
Total # Paitent Days	=	121
ALOS		12.1

CONCLUSION: Although the figures for 1981 show no reduced LOS with pre-discharge planning, the 1982 data does show a decreased LOS of one day.

Since the program was new in 1981., not all hip replacement patients were as consistently referred as in 1982 wnen the procedure became more routinized by orthopedic clinic nurses. Therefore, we wonder if 1981 patients referred were those patients who were more clearly identified by the orthopedist and his nurse as having potential for problems with discharge planning.

Although the original intent of the project was to contact every patient referred before hospitalization, decreased Social Work staffing in 1982 necessitated seeing hospitalized referred patients and not contacting some of the pre-admission referrals until they were actually hospitalized. We had also hoped to expand the program to other planned elective surgery procedures such as mastectomies, colostomys, amputations and radical neck surgeries, but staffing again limited our expansion of services.

Appendix D
(Continued)

CONCLUSION: (Cont.)

Subjectively, patients report satisfaction at the pre-hospitalization contact. The reality of their post surgery care needs is reinforced and we suspect that with more time to plan, that more patients are able to make an adequate home plan with Home Health Physical Therapy services if needed and may even avoid the SNF stay which would be more cost effective. Perhaps further study should be done on differences in placement, home or SNF, to see it there are differences in those patients contacted before hospital admission.

PLAN:

This study will be presented to:

1. Social Service Department.
2. Orthopedic Department.
3. Quality Assurance Committee.
4. Utilization Review Committee.

August 1982
Patti Lawler, R.N.
Celia McKinney, M.S.W.

(Continued)

SEND TO: SOCIAL WORK DEPARTMENT
BKMC

Chart Number	Group	Eff.Date
Membership Number	H.I. Number	

PRE-ADMISSION DISCHARGE PLANNING ASSESSMENT

Diagnosis _____ Phone No. _____

Surgical Procedure _____

Date to be Admitted _____

PRE-ADMISSION STATUS

Living Situation:

- ☐ Alone
- ☐ With responsible spouse or Caretaker
- ☐ Other _____

Facility:

- ☐ House or Apartment
- ☐ Retirement Home
- ☐ SNF/ICF
- ☐ Other _____

Locality:

- ☐ Portland Metro Area
- ☐ Outside Portland Metro Area

Estimated Length of Hospital Stay _____

DISCHARGE NEEDS

- ☐ Return to pre-admission living situation
- ☐ Home Health
- ☐ SNF
- ☐ Assistance with activities of daily living

Doctor: _____ Date: _____

FOR INSTRUCTIONS SEE REVERSE SIDE

12310 1/81

INSTRUCTIONS FOR USE OF

PRE-ADMISSION DISCHARGE PLANNING ASSESSMENT

1. Clinic Nurse - Initiates and forwards to Social Work at BKMC.
2. Social Work - Completes and retains white copy.
3. Admitting - Forward yellow copy to floor on day of admission.
4. Floor Nurse - Includes information in nursing assessment and discard.

Not part of permanent record.

APPENDIX I

MEDICARE INTERMEDIARY LETTER

Medicare
Part A Intermediary Letter
Part B Intermediary Letter

Department of Health and Human Services
Health Care Financing Administration

MEDICARE
AUG 1 1980
LIAISON DIVISION

Part A No. 80-24
Part B No. 80-20

Date July 1980

SUBJECT: HMO Demonstration Projects Under Medicare

The Office of Research, Demonstrations and Statistics, HCFA, is sponsoring a series of seven demonstration projects designed to test the impact of prospective capitation contracting with no retroactive adjustments under the Medicare Program. Under the demonstration projects, each HMO will receive a monthly capitation rate for each enrolled Medicare beneficiary, which will encourage cost efficiency under the Program. In addition, the projects will demonstrate incentives to the Medicare population to enroll by returning HMO savings as increased benefits and/or reduced cost sharing. It is anticipated the Program will achieve cost savings by contracting for benefits at a rate lower than average Medicare fee-for-service costs. These projects are expected to increase HCFA's experience with prepaid capitation contracting, and provide needed information for policy, planning, and legislative recommendations.

Each demonstration project is undergoing a 12-18 month developmental period before becoming operational. Each project will be operational for approximately 3 years. A total of 11 HMOs may participate in the projects, of which four are federally qualified.

The first project to become operational is the Fallon Community Health Plan in Worcester, Massachusetts. The Plan has completed marketing activities in its enrollment area, and the effective date of its initial enrollees was April 1, 1980. As described in Part A Intermediary Transmittal #815 (Carrier Manual Transmittal #779), Fallon will reimburse all providers, including those rendering out of area emergency and urgently needed services (except Part B bills for dialysis and related services). This will be the first HMO operating under this option. The Greater Marshfield Community Health Plan in Marshfield, Wisconsin and Kaiser-Portland (Oregon) have also begun enrolling beneficiaries, with effective dates of June 1, 1980 and July 1, 1980 respectively. Both Plans will reimburse all providers (except Part B bills for dialysis and related services). It is anticipated that other HMOs participating in the demonstration projects will also follow claims processing option "C."

HCFA-Pub. 60AB

*U.S. GOVERNMENT PRINTING OFFICE: 421-100/15225

U.S. DEPARTMENT OF
HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
OFFICE OF RESEARCH AND DEMONSTRATIONS
6325 SECURITY BLVD.
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U.S. Department of Health and Human Services
Health Care Financing Administration
Office of Research and Demonstrations
HCFA Pub. No. 03184 September 1984